Patterson LAW

1801 Hollis Street, Suite 2100
Halifax, Nova Scotia B3J 3N4

Tel 902.405.8000
Fax 902.405.8001

Toll-free 1.888.897.2001
www.pattersonlaw.ca

October 7, 2022

By E-Mail

Mass Casualty Commission
310-1791 Barrington Street
Halifax, NS B3J 3K9

Dear Commissioners:

Final Written Submissions
Our File Number: 4203561

We make these submissions on behalf of our clients, survivors and families of the victims, those designated as participants most affected by the mass casualty event.

Since April 2020, our clients have relived their worst days, publicly, through their advocacy for and attention to this Commission. They have done so in the hopes that some meaning and benefit can come from their loss – that what helped them following their loss may help others, and significantly, that what hurt them will never be repeated. As with our oral submissions, our clients' contribution takes the form of reflecting upon their harms and losses and the essential take-aways from the evidentiary record, and directing the Commission to the areas in which recommendations are needed.

We stress that these written submissions are made in conjunction with all earlier oral and written submissions made to the Commission, as well as input the Commissioners will have received directly from those of our client group who participated in small group sessions or participant consultations, or those of our client group who have otherwise offered facts about their experience to the Commission that warrant careful reflection. The limits of these written submissions do not enable us to reproduce in this document all of our and our clients' prior input, but our clients trust that the Commissioners will review these submissions alongside everything that we and they have submitted to the Commission to guide the Commissioners' findings about 'what happened' in and around April of 2020, and why and how, and recommendations flowing therefrom.

Our clients' recommendations, as discussed herein, fall within five broad categories, namely, supporting victims, communications, public alerting, RCMP training, tools and

modernization, and the future conduct of commissions of inquiry involving victims of trauma. That we have prioritized these areas and the particular comments herein must not be misinterpreted as devaluing or negating any submission or input previously offered to the Commission in other written and oral forums where the same does not fall neatly within these categories or the discussions we are able to include within these pages.

RECOMMENDATIONS FOR SUPPORTING VICTIMS

We begin our submissions with a focus on those individuals and families we represent, those who experienced this mass casualty event and continue to live through the days, weeks and years that followed.

Next of Kin Notifications and Information Seeking

Many of our clients' experiences began with a desperate search for information about their loved ones. The story of their interactions with those who held the information they sought must be used as cautionary tales. While the information sought will always be traumatic, this Commission must use our clients' stories to craft recommendations that ensure the process of seeking information following a tragedy itself does not exacerbate or create trauma.

The Commission is familiar with these stories. While we will not belabour them here, some examples bear repeating, including

> Patsy Bagley who knew early on that her husband, Thomas Bagley, was missing. He was identified to RCMP as deceased just after 11:00 a.m., just before the perpetrator's capture.[1] In spite of being positioned only roughly 250 meters away, Mrs. Bagley was made to wait three agonizing hours to learn of her husband's death.
>
> Nick Beaton, who was communicating with his wife, Kristen Beaton, on April 19, 2020 when she suddenly stopped responding to him. He pleaded with the RCMP to provide him with information on his wife and unborn baby's location for hours, sending friends and family to search the area as he stayed at home with their young son. The RCMP confirmed to Kristen's employer that she was "no longer considered missing" at 12:49 p.m.[2] Members gave Mr. Beaton no confirmation of Kristen's death until nearly 6:00 p.m., moments before the rest of the public was briefed about the mass casualty event in a presentation to the media.

---

[1] Foundational Documents "2328 Hunter Road", at para 74, P-000288 (COMM0002885), and Member Report of Richard Harvey, P-000315 (COMM0013937)

[2] Response Report to the Nova Scotia Critical Incident, Victorian Order of Nurses for Canada - Nova Scotia Branch (VON Nova Scotia), P-000478 (COMM0049653)

> Connor Reeves, son to Corrie Ellison, who never received a next of kin notification for his father's death at all. His existence was inexplicably unknown to members of the RCMP tasked to engage with victims' families.[3]

In the absence of any proactive information sharing from the RCMP, our clients put themselves in harms way to find information about their loved ones. Many, like the O'Brien family and Dan Jenkins, approached scenes and were greeted by terrified RCMP members with guns who responded confrontationally and threateningly. In spite of being turned away, they had to continue to pursue information rather than receive contact from the RCMP.[4]

Our clients submit that the evidentiary record indicates that the RCMP made inadequate attempts to either proactively or reactively provide information to those seeking it. The deficit was also apparent in the RCMP communications to the broader public, as discussed more fully below.

Our clients state that it seems that the RCMP was wary of providing any information to families before they were certain of its truth and of the advisability of sharing it. While, of course, the police cannot relay uncertain information as if it were certain, we suggest that frequent and consistent updates must be given to those most likely to be impacted by the crime. This approach is supported by the Commissioned Report of Dr. Jaclyn Schildkraut entitled, "Supporting Survivors and Communities after Mass Shootings." There she wrote:

> *To avoid exacerbating grief and trauma associated with death notifications, it is important that all potential survivors be provided with regular informational updates, even if it is to let them know that there is no new information. Providing them with a time of when they can expect another update (e.g., 30 minutes) also may be helpful.*[5]

In light of our clients' experiences, our clients submit that in the event of a mass casualty event, governments and/or the RCMP must provide both virtual and telephone access to information, as well as a safe physical location for people to gather. Information about such a location and contact number must be clearly provided to those seeking information and to those who might be asked for it. Updates must be provided on a regular schedule even if those updates include no new information. Proactively, persons most in need of

---

[3] Transcript of Recorded Interview of Wayne (Skipper) Bent, a p. 14, P-002313 (COMM0057740)

[4] Foundational Document "Plains Road, Debert", at paras 89-90, P-000417 (COMM0053598); Foundational Document "2328 Hunter Road", at para 55, P-000288 (COMM0002885)

[5] Schildkraut, Jaclyn, "Supporting Survivors and Communities after Mass Shootings", P-002619 (COMM0058367), at page 4.

information, such as those "most affected" by a mass casualty event, ought to be diligently listed or catalogued and flagged for meaningful follow up in a timely manner.

Our clients further ask that this Commission make recommendations relating to training and procedures for timely and effective next of kin notifications. All members of policing agencies must be properly trained on the process and protocol of performing a next of kin notification, which must also include reflection on the completion of that task if/when further information becomes available (i.e., if they obtain knowledge of a more immediate family member). When possible, we suggest that a family liaison officer should accompany an investigating member when providing notification of a death by crime. When a family liaison officer is not available to accompany an investigating member or involving one would cause undue delay, the investigating officer must provide details as to when and how the family liaison officer will make contact.

Family Liaison Officer

The facts and recommendations set out above speak to what our clients needed as the event was unfolding, and in the hours immediately following the perpetrator's death. As is evident through the work of this Commission, the needs of victims and their loved ones shift as the active event ends and the aftermath ensues, and policing agencies like the RCMP must adapt accordingly.

Cst. Wayne "Skipper" Bent was a central figure in the families' lives following the mass casualty event. He was appointed the sole "family liaison officer" to support the families of the perpetrator's victims (but apparently not other survivors of the mass casualty event, not even the RCMP's own victims Darrell Currie and Greg Muise). This role was half conceived by the RCMP when assigned to Cst. Bent, and our clients submit that the evidentiary record makes clear that he was undertrained, overwhelmed and subject to no oversight or intervention.

The mass casualty event has plainly demonstrated just how crucial this role of "family liaison officer" is, and the Commission's recommendations must clarify this role. While there are many discussions which support the de-tasking of this role from police, there is cause to recommend that this role remain within the purview of policing agencies. Victims require a direct contact within the police agency in order to obtain the most accurate and up to date information on the investigation – funnelling such information through multiple contacts is dangerous, insufficiently responsive, and risks fostering disconnection between victims and the policing agencies serving them. Our clients submit that, rather, victims and survivors need a guide versed in police procedure and evidentiary details specific to their circumstances, and they need this assurance that the policing agency is working toward the victim's and survivors' best interests. A family liaison officer should offer meaningful updates and guidance through the police agency's work, as well as general information on

related offices and services, including, but not limited to, the medical examiner, insurance, crime scene and evidence cleaning, and mental and physical health supports.

It is important to note that the victims and survivors of crime must not be infantilized by the police or protected from information in the guise of being "trauma informed." This is particularly the case when it comes to viewing remains, scenes or evidence. While no victim or family member should ever be forced to view remains, scenes or evidence with indicia of trauma, the opportunity must be provided to them in the most dignified and respectful way possible. Critically, victims and survivors of crime must also be offered crime scene and evidence cleaning services prior to those items being returned to survivors by either the police or the office of the medial examiner. This should be at no cost to the victim. While it is 'bare minimum' to recommend that victims and survivors be guided to such services, it is clear from the mass casualty event that there must be means to further aid victims and survivors in such processes.

There must also be clear communication from the family liaison officer as to the current location of remains and the process for identifying and releasing those remains. Though much of this process and procedure will fall to the office of the Medical Examiner, the initial information about this process must come from the police agency when the notification of the death is made.

As to evidence, the family liaison officer should be made aware of all personal effects in the possession of the police and the medical examiner and must provide that list to members of the family. Reasons for the retention of each item should be explained. It is apparent that trauma has been aggravated following this mass casualty event related to the mystery of what evidence was seized and retained, and why, and the fact that two and a half years later, questions about loved ones' personal effects still remain.

In our submission, all detachments, or regions at the least, must have one trained, full time, family liaison officer. In situations such as this, it will become necessary to call in additional officers from other detachments but there must be sufficient local knowledge of resources and services which can only be properly maintained by members of the local community. Further, family liaison officers must meet the victims where they are and use means of communication tailored to each victim. To the extent that a tasked family liaison officer or officers cannot meet these basic requirements, it is incumbent upon policing agencies to replace or supplement that family liaison officer, as the circumstances may warrant. To that end, our clients submit that recommendations must be made for better (or any) oversight over how policing agencies like the RCMP carry out this role, to ensure that family liaison officers are not left to self-assess and flounder, at victims and survivors' expense.

Mental Health and Other Supports

In their interviews with the Commission and in their small group sessions/participant consultations, the Commissioners will have heard from our clients of the concerning lack of access to appropriate and timely mental health support following this mass casualty event.

With its joint federal and provincial mandate, our clients submit that this Commission is in a unique position to recommend improvements to the current state of mental health support both within Nova Scotia and across Canada.

Our clients feel that there must be better integration of mental health care with more "traditional" styles of health care. Mainstreaming and destigmatizing mental health care requires better integration of same into the health network, both from a practical service level and from a funding perspective.

After the mass casualty event, our clients had great difficulty in finding health care providers who were able and willing to help them through their complex trauma. Some have yet to succeed. The Commission will have heard from several of our clients of being simply provided a list of potential mental health service providers and being left to navigate that on their own, wading through treatment providers with limited experience, capacity and accessibility. The Commission will have heard about difficulties with securing funded services by bureaucratic issues like not having a family physician to sign a form to support the need. Our clients submit that it must be a recommendation of this Commission that victim support services must do more than provide a list of names and a form to fill out. Rather, there must be true navigators assigned to assist victims in completing paperwork, including engagement with third parties' whose input is required, and finding the right practitioner for their particular needs. In the wake a of a mass casualty event, the surviving victims and family members of those who are killed have many, many tasks thrust upon them. Expecting them to make the phone calls and organize mental health appointments while coping with the weight of their unexplained losses and reorganizing their lives is a clear failure on part of our government and service providers to support their community members.

The Commission will also have heard the particular concerns of those of our clients who live outside of Nova Scotia. Though they were offered victims' services, those services were physically and technologically located in Nova Scotia, making them very difficult to access. Simple barriers like not even having a corresponding list of service providers from other Canadian provinces or not having a toll free number for non-Canadians have imposed upon grieving family members in a way that was completely unnecessary. Our clients submit that there must be better communication and integration between victims' services across this country and, at a minimum, greater awareness of and greater efforts to navigate and overcome the barriers faced by those from outside of Nova Scotia and Canada who are touched by the violence which may take place here.

Several participants, including Mallory Colpitts and Leon Joudrey, were physically displaced by their trauma, unable to remain in Portapique following the mass casualty event. In the case of Ms. Colpitts, she had difficulty selling her home and in finding a new place to live. She stated that a possible buyer had difficulty getting a mortgage approved due to the tragedy, and that she incurred significant hardship in transitioning to a new home[6]:

> *[F]or someone like myself to do a relocation, it was … the move from Portapique to the new residence, while I waited for the build, which meant months of storage, which then meant another relocation move, after I just spent somewhere between $10-14 thousand on a septic bed, I didn't exactly have the funds to support all that with a new purchase. And because of the housing crisis and finding a difficult place to stay, staying with family was what I had to deal with. That's what I had to resort to, given the situation.*

Further insight was given by Ms. Colpitts in relation to the failure of the Red Cross to provide her, a survivor, with any financial support, despite its mandate to do so.

Our clients submit that recommendations must be made for funding from the governments, to assist surviving victims with the financial impact of their losses, which include: the lost value of their properties due to the mass casualty; moving costs; temporary housing; realtor services; and other costs related to being physically displaced. To the extent that financial support is notionally made available to such individuals, there must be measures put in place to ensure that such funding actually reaches them, that these victims are not forgotten – there must be greater accountability with respect to identifying to whom funding should be available, and how. Recommendations must reflect the priority of dealing with these issues proactively in future tragedies, such that those most affected are not dealing with logistics and financial hardships, or the surprise that promised funding is no longer set aside for them.

RECOMMENDATIONS FOR COMMUNICATIONS

Though, at its core, effective communication is a means of support for those experiencing a mass casualty event and its aftermath, we have chosen to address communication-related recommendations under this combined heading.

Our clients, and all members of the public, suffered from a lack of communication from the RCMP throughout the mass casualty. Our clients submit that this Commission must make

---

[6] Interview with Mallory Colpitts, P-005395 (COMM0061175) at p. 14.

fulsome recommendations to improve RCMP communications. This encompasses both internal RCMP communications, and RCMP communications with the public.

External Communications

Reliance on Twitter during the mass casualty

The RCMP's non-use of Alert Ready is addressed in a subsequent section. We will not here belabour whether it was or should have been a 'tool in the RCMP's toolbox.' Our clients feel it is difficult to disagree that the RCMP had years of advance notice of the existence of this tool and its potential for policing purposes, but disregarded that opportunity, which sufficiently responds to the 'toolbox' defence the Commission has repeatedly heard.

The RCMP's choice to essentially exclusively use Twitter to communicate with the public during the mass casualty event, however, is a decision our clients herein again decry and state that the fatal consequences of same were obvious. Recommendations must be made specific to the inadequacy of using Twitter in these types of events, at least on it own, as well as on a day-to-day basis. Specifically, these recommendations should address the use of Twitter in a general sense (i.e., efficacy of language, employment of social media tools like #hashtags), as well as the specific procedures for using Twitter during a policing response.

As was clear throughout the proceedings, many of the victims, their families and other residents of Colchester County did not use Twitter, specifically, and many did not use social media more generally. That aside, however, our clients submit that it is reasonable to assume many people who are users of Twitter are not engaging with Tweets about a vague weapons-related complaint in Portapique, late on a Saturday night and during a pandemic. Given the hour, the location, and the possible range of the threat, an intrusive alert would have been vastly more effective, and much better reflective of the tragedy which was unfolding and putting communities at risk.

Though there may be instances in which Twitter is a useful tool for alerting the public, it is not a panacea; our clients submit that recommendations around the use of Twitter in any active policing response, particularly a crucial incident that few are aware is occurring, must include common sense assessments of the context of a given emergency, including the population demographics and internet/computer accessibility, nature and reach of the threat, and the likely use of Twitter considering time of day.

Regarding issues specific to how Twitter was used in this instance, our clients submit that the messaging early on was wholly inadequate in informing the public. The first tweet issued by the RCMP on April 18, 2020, at 11:32 p.m., alerting of a "*firearms complaint*" greatly understates the facts and the threat known to RCMP – this messaging was, at best, vaguely accurate, if not better described as false in its failure to properly convey the harms perpetrated and the risk to which the broader community was exposed.

As stated in previous submissions, the bureaucracy inherent in issuing a single tweet proved deadly the next morning, when over two hours passed between when the RCMP learned that the mock cruiser was not among those vehicles burned out in Portapique, and when a tweet was issued warning the public of the perpetrator's use of the mock cruiser. In that time, Thomas Bagley, Lillian Campbell, Kristen Beaton, and Heather O'Brien were murdered by the perpetrator. This specific failure to warn of the perpetrator's disguise says nothing of the broader failure to warn of the risk he presented to the province, when the RCMP itself did not know of the perpetrator's whereabouts and allowed that he could be anywhere (though our clients submit that the evidence supports that the RCMP did not actually believe that a likely possibility).

Following from the above, our clients submit that there are two areas wherein recommendations need to be made.

First is the actual procedures for issuing tweets and other alerts. Information that is disseminated to the public must be accurate to what is known to police and must accurately convey the threat to the public, and information must be shared as contemporaneously as possible. Timeliness of alerts and messaging cannot be sacrificed for the sake of redundant sign-offs. There must be contextual assessment of urgency when determining whether to delay alerting the public, and flexibility in how messaging gets out. Our clients submit that there can be no other method of warning the public that is acceptable, in a critical incident or otherwise, than honest disclosure to the public about a public safety risk and how citizens should protect themselves in a manner that actually reaches them as quickly as possible.

The second area for improvement is in the culture of the RCMP, a point we touch upon elsewhere in these submissions. Our clients submit that the bureaucracy inherent in the institution, and a culture of looking to someone else as the responsible person (whether up the chain or down), incentivizes individuals to decline to take ownership of tasks like warning the public and to endorse or accept the practice of having multiple people sign off on action items unnecessarily.

Community engagement in and around Portapique on April 18-19, 2020

Our clients submit that efforts to engage with Portapique residents during the mass casualty event were insufficient, and in some cases leading to serious and long-lasting impacts.

As was stated in our oral submissions, the most striking example of the failure to share community knowledge arose from the unacknowledged and unrepeated transmission by Cst. Colford. What is more, however, is that Cst. Colford, along with other members tasked in the Portapique area over April 18-19, 2020, failed to take advantage of the most valuable resource available – the residents of Portapique.

There is no evidence to support that meaningful efforts were made to seek information from those residing in the community, whether to confirm reports of the perpetrator's disguise or how he might escape from the community, not the least of which are those of our client group who lived through the event in Portapique – Mallory Colpitts, Bernie Murphy, Leon Joudrey, Richard Ellison, and the Blair and McCully children. Limited information which was received appeared to have been inadequately acted upon or handled, if at all, and in some instances appears to have been simply disbelieved. Beyond members of the community, the Commission also has in its evidentiary record other instances when opportunities for information were overlooked or ignored, such as other first responders involved in the mass casualty event or other community resources.

While there are practical and training related recommendations that stem from these failures, some of which we speak to elsewhere herein and which our clients trust will be addressed by the Commissioners in their recommendations, our clients are of the view that the crux of the issue is that the RCMP (and all policing agencies) must learn to trust local knowledge and to believe the information that is being relayed to them. The mass casualty event has demonstrated the tragedy that resulted from the RCMP's failure to make obvious efforts to work with those best positioned to support it – the community it was there to serve.

In terms of more specific recommendations, following from the above, our clients submit that it is apparent that certain policies and procedures must be reduced to written policies/directives and must form part of critical training for responding members, in both a critical incident and as part of day-to-day good policing practices.

Our clients submit that there must be clear radio procedure and instructions for relaying important information over the radio in an active IARD situation. This training must include procedure for confirmation and acknowledgement from members in command. Individual officers should take responsibility for the messages that they mean to transmit, such as the existence of a comfort centre, and not assume that they have been heard and responded to appropriately. Individual members should also take responsibility for ensuring their knowledge is disseminated, such as recognition of a push bar on a mock police cruiser, and not simply assume that other members have the same knowledge.

While safety is paramount, recommendations must include safe means to extract information from persons leaving the scene, or at least tracking their identity and whereabouts. While it may have been dangerous to have members detain persons at the entrance to Portapique to ask about what they had seen within or what knowledge they had of the community, our clients submit that there clearly ought to have been plans in place for secondary locations in which this information can be collected, so that the identities and observations of individuals like David Faulkner, for example, would not have remained a mystery for so long.

In this particular situation, importantly, intelligence gathering could have been combined with evacuation of residents and canvassing of the local area.

By not canvassing the area, the RCMP allowed further harm to come to residents. As stated by Bernie Murphy in his interview on January 11, 2021,[7] he did not hear from the RCMP until long after the incident was over. In his interview, he described the experience of not knowing:

> *I never talked to a police officer until after [the perpetrator] was dead. I seen them driving by, waved at them, stood there … See, I was in a unique position because I'm a 52-year-old bald, white man. So, I wasn't sure who was going to kill me, the psycho in my neighbourhood or the cops thinking I was the psycho in my neighbourhood.*

Bernie Murphy died in December of 2021. As the Commission will observe in a statement currently being submitted by his brother, Darrin Murphy, Mr. Murphy believes that the effect of the stress of this event had a negative impact on Bernie's health. It is hard to know if having the RCMP engage him sooner on April 19th would have improved Bernie's trajectory, but it cannot be challenged that Bernie suffered in those early hours of the 19th, when he bore the fear of being misidentified as the perpetrator, not knowing what the RCMP knew of the perpetrator's whereabouts.

Our clients submit that this Commission should make a finding of fact that it was a failing of the RCMP not to proactively update residents during the mass casualty event, much less take care to ensure their safety. Further, recommendations should be made as to how those in proximity are engaged with by policing agencies, in efforts to alleviate the trauma and keep residents safe.

Public communications following

Throughout the Commission's work, it has been learned that information released by the RCMP in the days and weeks following the mass casualty was on a number of occasions inaccurate. Examples include C/Supt. Leather stating in a press conference on April 19, 2022, that the number of casualties was "*in excess of 10 people*" when RCMP knew the number was significantly higher. In that same press conference, he also stated that the perpetrator was not known to police, which was not accurate.

Throughout public proceedings in the summer of 2022, our clients submit that it became clear that in the immediate days following the mass casualty event, that Commissioner Brenda Lucki received, and acquiesced to, political pressure to release information about

---

[7] Statement of Bernie Murphy, COMM0061160.

guns used by the perpetrator. Our clients submit that Cmmr. Lucki's reaction to this information *not* being released belies the suggestion that she merely received curiosity about whether it was being shared, or that she was simply perturbed because she had been caused to misinform on the matter.

If a desired outcome of this Commission is that our clients and the public begin to regain trust in the RCMP, recommendations need to address the lack of transparency exhibited following the mass casualty event. This may be an issue addressed at the level of Strategic Communications, or it may be an issue more intertwined with a culture of obfuscation and withholding information. Regardless, dissemination of information is essential in fostering public trust in the institution. Overlaying this, most essentially, must be a focus on serving the affected communities and serving public safety as a whole, and no other agenda whatsoever. Our clients trust that the Commissioners, through their recommendations, will ensure that the RCMP has the guidance it requires to properly focus on accuracy, transparency and service to the public in post-event communications in the future.

Internal Communications

Internally, our clients submit that it is apparent that the RCMP response was chaotic. Despite the submissions of other participants before the Commission, our clients maintain that the evidentiary record does show confusion in the ranks as to who was in charge of the response.

In his interview with the Mass Casualty Commission, Cpl. Trent Milton put it as follows:

> *So, there was definitely some concerns with communications during this phase of the operation. There was a lot of chaos that happened. All communications were going over the…the one channel. So, there was….although the CIC has overall control of the situation, there seemed to be too many cooks and not enough…or too many…whatever the saying is, right, in the kitchen […] Too many cooks in the kitchen, right, and people….there was no real control over where resources were being deployed at that point in time.*[8]

Our clients submit that, throughout, the RCMP response to the mass casualty event suffered from a lack of overall tactical strategy and an inability to view the larger picture.

In most cases, when a shooting was reported, the near entirety of the RCMP response moved from one location to the next in convoy. Our clients submit that there did not appear to be strategical guidance regarding roadblocks or direction of travel. While not wishing to discount the accomplishment of Csts. Hubley and McLeod, our clients state that

[8] Interview with Cpl Trent Milton, P-000415 (COMM0037115) at p. 70

it cannot be forgotten that the perpetrator was ultimately thwarted by an empty gas tank and coincidence, not by master strategy.

The desire of all members appeared to be to chase down the suspect. While laudable, our clients submit that this focus appears to have resulted in little attention having been paid to effective scene security, evidence gathering or other important duties (including victim support) until after the death of the perpetrator.

When members were assigned to such tasks, there are too many examples of members not completing tasks as fully as they ought to have been. For example, Cst. Colford did not ensure that her critical information about an alternate exit from the community was received and handled, members failed to accurately circulate intelligence received, and Cst. Dorrington expressed that he felt unable to properly canvass the area on the morning of April 19th because of his lack of a partner and as a result, failed to direct his attention to a thorough search, resulting in tragic oversight at Cobequid Court.

Our clients submit that the communication issues became apparent very early on. Communication around containment during the initial response to the mass casualty event failed to be timely and comprehensive. It remains difficult to understand how, in efforts to contain the area in and around Portapique, no containment point was set up to the east until approximately midnight. This appears to be easily rectified by having one person looking at a map and overseeing coordination, as opposed to having containment responsibility diffused across many brains.

Our clients submit that S/Sgt. O'Brien's involvement on the radio only further confused matters in the initial hours of the mass casualty. At that time, there was little clarity as to who was in charge and from whom direction should be taken. Our clients submit that having S/Sgt. O'Brien parachuted in at this time, without a clear indication of the command structure for those on the ground, was problematic. The Commission is also aware of concerns raised about S/Sgt. O'Brien's involvement given he had consumed alcohol in the hours before his command involvement on April 18, 2020. We cast no aspersions on S/Sgt. O'Brien for having a few drinks on a Saturday night when he was off, but quite plainly, if he drank enough that he couldn't operate a vehicle, our clients state that he should not be involved in commanding a critical incident response when lives were being lost. It is difficult to acknowledge any other public-serving job where that kind of decision would be acceptable.

Our clients submit that the Commission's recommendations also need to address the issues related to reporting up, which impacted command decisions overnight on April 19, 2020. In his evidence before the Commission, S/Sgt. West acknowledged that he did not know that points east of Portapique were uncontained for an hour and a half after the last sighting of the perpetrator by Andrew and Kate MacDonald. It stands to reason that the

command teams would not have so strongly held the belief that perpetrator was still in Portapique – a theory which existed well into the morning of April 19, 2020 – had the Critical Incident Commanders been aware of the lack of containment east of Portapique, particularly when recognition of the existence of the Blueberry Field Road finally occurred.

RECOMMENDATIONS RELATED TO PUBLIC ALERTING

Once again, issues with public alerting fall within the broad category of communications, but are very much deserving of their own section for reflection and recommendation. Public alerting has been heavily canvassed throughout the public proceedings, and our clients' position should come as no surprise. As stated elsewhere, our clients feel that the content of the RCMP's public communications during the mass casualty event was misleading and its method was totally inadequate. The public alerting system, Alert Ready, absolutely and unequivocally should have been used on April 18 and 19, 2020, to ensure the public was aware of the risk masquerading through their communities. The fact that it was not, our clients submit, resulted in preventable deaths.

Our clients submit that in instances where the public is in danger communication from public safety agencies must be timely, accurate, and wide-reaching. If utilized, the Commission has learned that public alerting systems such as Alert Ready can easily achieve these goals. Our clients submit that the Commission has received extensive evidence supporting that in this instance, Alert Ready was the best method available to warn the public, and there was every opportunity for the RCMP to include it within its 'toolbox.' The evidence has shown that the RCMP was notified of Alert Ready years prior to April 18 and 19, 2020. However, as an institution, it failed to retain or contemplate this knowledge of the system's capabilities, actively declined obtaining "trusted user" status, and did not possess the ability to make "creative" decisions such as applying this resource in a way that was novel to them (much less remembering or recognizing its existence), at least, not until it was too late.

Our clients submit that there is a wide body of evidence supporting that the RCMP should have known about, and should have used, Alert Ready. Exemplary items include Truro Police Chief Dave MacNeil and Halifax Regional Police Chief Dan Kinsella's comments on their agencies' then-existing understanding[9] of Alert Ready, as well as the RCMP's own use of Alert Ready in instances immediately following the mass casualty event, up to and including the very recent tragedy at James Smith Cree Nation in Saskatchewan.

While it is impossible to know how the events would have changed had Alert Ready been used, many of our clients believe that it may have saved their loved ones. Among our client group, we have identified that the evidentiary record proves that Thomas Bagley, Kristen

[9] Mass Casualty Commission Proceedings, June 6, 2022 and August 25, 2022

Beaton, Heather O'Brien and Joey Webber were all carrying their cellphones. It is highly likely that they would have received an alert. None were sought out specifically by the perpetrator – rather, they were killed opportunistically. They and their loved ones were in communication that morning, checking social media, sharing information, and trying to stay informed of the events which they heard had occurred in Portapique. It is not a stretch to infer that each of these individuals would have acted differently had they been alerted of the nature, even ill-defined location, and severity of the risk. Had they been instructed to shelter in place, they may well have done so. Our clients submit that the RCMP's failure to modernize and adapt to readily available technologies and to employ them effectively is plain in the deaths of these (and likely other) individuals, not to mention the harms borne by countless others who are affected by not being properly warned or instructed about the risk that was driving through their communities. The stakes of shrugging off the opportunity to adapt our public alerting system into policing, as April of 2020 proved, was a matter of life or death. This cannot be overshadowed by the suggestion that the RCMP agreed to use Alert Ready (albeit when the Emergency Management Office became impatient with the RCMP's failure to ask to use it), particularly when there is every reason to believe that the RCMP's ability to draft and disseminate a public alert would have been fraught with the same bureaucratic hurdles as its Tweets.

Our clients again urge the Commission not to be taken in by the purported "pitfalls" identified with use of Alert Ready, particularly where those comments come from those who were responsible for it not being used in the first place. The Commission has received ample evidence before it supporting the efficacy of Alert Ready, including that from municipal police chiefs identified above, as well as many Phase II contributors. Our clients submit that it is apparent that it is vastly better to provide what may only be a potentially imperfect alert to as many people as quickly as possible, than to provide no alert at all – to use the words of our client, Ryan Farrington, "*I'd rather be scared than dead*."[10]

RECOMMENDATIONS FOR RCMP TRAINING/PREPAREDNESS, TOOLS, & MODERNIZATION

Training

It is our clients' submission that there are several areas where RCMP's training and overall preparedness in advance of the mass casualty event left much to be desired in terms of the RCMP's response. These include the key subject areas of IARD training, cultural competency and local knowledge, interoperability, succession planning, and the family liaison role (which we have discussed at length). Training could additionally benefit the

[10] Small Group Session Transcript - Ryan Farrington, son of Dawn and Frank Gulenchyn, COMM0065231 at p 4, lines 3-4.

RCMP by ensuring effective use of existing technological resources, and this topic will be discussed further under the below subheading *Tools*.

IARD and decision-making

We have heard the phrase Immediate Action Rapid Deployment, or "IARD," throughout the course of the public proceedings and in associated documents. The Commissioners will be aware that it was the mode of response actioned by the first RCMP members to arrive in Portapique on April 18, 2020, Csts. Beselt, Patton, and Merchant. The Commission heard in witness testimony from these three members that IARD training is practical; that trainees execute IARD responses to realistic scenarios conducted in a training facility made to resemble a real-world location. The Commission also heard that these training scenarios are almost exclusively reflective of indoor events, and are typically conducted in buildings resembling or currently in use as schools. While the various items of the evidentiary record suggested that IARD is intended to be adaptable to different scenarios, our clients submit that it is obvious that the method itself, and the associated training, were developed with school shooting scenarios in mind, as supported by the witness testimony of Csts. Beselt, Patton, and Merchant.

It is apparent that this focus on IARD in the context of school shootings, whether explicitly intended or not, resulted in RCMP members, including commanding members, being ill-equipped to translate this training to a different environment. By contrast to a school building-type of environment, the physical environment of Portapique on the overnight of April 18-19, 2020, was vastly different. Members were responding outdoors, in the dark, with variations in terrain including roads, ditches, buildings, and densely wooded spaces. Our clients submit that the RCMP's inability to respond productively and efficiently in Portapique is obvious not only in what it accomplished (or failed to), but in members' own testimony, demonstrating a lack of preparedness for this physical environment.

The Commission heard members, through oral testimony and documentary evidence, express significant fears as a result of the environmental challenges, particularly that they could be located by the perpetrator if they used flashlights, that they were vulnerable to ambush outside of cleared areas such as lawns and roads, and that they may not be identifiable by other law enforcement and were therefore vulnerable to "blue on blue" use of force. In contrast, the Commission heard members express that they were able to execute certain other tasks almost as second nature, because of their practiced repetition through training (such as was expressed by Cst. Beselt in his live testimony). Our clients submit that this 'second nature' deployment of skills indicates that members would not have been as susceptible to the specific fears which they expressed, had they been trained in and practiced how to respond in a dark, outdoor, forested and otherwise unfamiliar physical environment.

Our clients submit that the remedy here is obvious – in the absence of any evidence to support that more robust IARD training can be accomplished, recommendations must reflect that police response training, particularly IARD training, must be enhanced in order to give members the skills and tools they need to make confident decisions in critical responses executed outside of a lit-building within a limited timeframe. However, rather than taking a reactive approach by encouraging training for another environment identical to that of Portapique, our clients submit that recommendations around enhancing or expanding IARD (or any other) training should focus on proactive training for any number of realistic scenarios which members might encounter in the area which they serve. Scenarios utilized could change year over year to expose members to greater variety and force them to practice the more creative decision-making aspects of forming an IARD response.

An additional area where poor outcomes may have been remedied by better training was the diversion of the ERT team and TAV to Five Houses in response to a report of a flashing light – away from the community in which the RCMP knew a crisis was happening to a community across a waterway where something potentially completely innocuous was happening, using the RCMP's only specialized resource active in the area.

The decision to deploy ERT resources away from Portapique to Five Houses engaged both command decision-making by S/Sgt. Jeff West, and practical decision-making by ERT leader Cpl. Tim Mills.[11] Cst. Trent Milton reflected on this decision as one that "*ended up chewing up a lot of our time*" when resources could have multitasked by splitting up instead.[12] While these observations were made with the benefit of hindsight, we again submit that additional or better training could have avoided what our clients submit was a lost opportunity to better respond in Portapique – to search for the perpetrator or victims/survivors, to inform/aid community members, to reflect upon intelligence received and overlooked. Members, particularly those in decision-making roles, should be able to confidently assess the priority of targets and the appropriate deployment of resources. The Commission heard witnesses, including, for example, Wallace Gossen,[13] discuss how police should be using decision-making tools at every point in their day-to-day practice, which our clients submit was lacking in the RCMP's response on April 18-19, 2020. Our clients submit that better discipline around continued use of these thought processes and decision-making tools, achieved through superior practical training and repetition, could have resulted in better decision-making when it came to ERT's fruitless redeployment to Five Houses. Ultimately, this relates again to recommendations surrounding more targeted and

---

[11] Foundational Document "RCMP Emergency Response Team (ERT), P-001370 at paras 72-81; Colchester Radio Transcript Dated 20202-04-19 at lines 1812-1819 and 1842-1843; Transcript of Recorded Interview of S/Sgt. Jeff West, P-001442 at p. 26

[12] Interview with Cpl Trent Milton, P-000415 (COMM0037115) at p. 52

[13] Mass Casualty Commission Proceedings, June 2, 2022

effective training, to ensuring that same is in place and carried out with reasonable frequency to ensure that such distractions do not adversely impact an RCMP critical incident response in the future.

Local knowledge and cultural competency

It is apparent that deficiencies in the RCMP response to the mass casualty event derived from members' lack of familiarity with the communities which they serve. During the mass casualty event, the evidence revealed concerns such as members having trouble orienting themselves or getting lost on multiple occasions (perhaps most critically in their inability to identify an appropriate place to stage near the Fishers' home). We also saw a lack of appreciation for Portapique residents' knowledge of their neighbours and the community, or their believability as individuals, despite no indication of a lack of credibility. Examples include the disregard for the veracity of the initial reports from Jamie Blair and Andrew and Kate MacDonald, containing crucial information about the perpetrator and his disguise, which appear to have been initially questioned or doubted, and just as concerning, simply unheeded. Our clients submit that this disregard indicates not only a lack of knowledge on the part of the RCMP *vis a vis* the communities they police, but additionally, a lack of trust in community members. This apparent lack of trust in the community, our clients submit, is rampant throughout the mass casualty event, starting with Jamie Blair and other Portapique residents not being relied upon for information, and culminating with the RCMP's apparent lack of confidence in the public's ability to respond responsibly to an accurate warning about what was happening in their backyards on April 19, 2020.

Much of the Commision's phase II work related to what the Commission has referred to as the "rural context" in which the mass casualty event took place. Our clients submit that much of the focus on the "rural context" throughout the public proceedings has been misplaced – the context of the mass casualty event is not dominated by its rurality. Rather, the cultures of Portapique, Colchester, Cumberland, and Hants counties, and Nova Scotia itself, are unique, just as any communities would be. Portapique is not simply interchangeable with any other small community to which the descriptor "rural" could be applied. Familiarity with communities served demands familiarity with the actual communities actually served by policing agencies, and enhanced by broader understandings of rural and other types of environments more generally.

To that end, our clients submit that recommendations must make it incumbent on the RCMP to ensure that their members are to the specific communities which they serve, rural urban or otherwise. Our clients submit that it must also be incumbent on the RCMP to ensure that their members have the requisite local knowledge to effectively serve the communities in which they are located. Members must know the local geography of their service area, and be able to identify gaps in their knowledge, as well as how to fill those gaps (which we will discuss further below, under the subheading *Tools*). Beyond this, understanding of who resides in and around communities, and their corresponding unique

cultures, is essential. Our clients submit that one recommendation which would positively impact members' abilities to achieve local knowledge would be to reduce the turnover and rotation of members in and out of communities.

While the Commission has heard RCMP witnesses argue that this constant rotation allows them to provide better services, because members acquire different experiences, our clients submit that it clearly has a negative impact on members' abilities to acquire cultural competency and local knowledge. For the reasons set out above, our clients submit that it is apparent that turnover actually did have a negative impact on the efficacy of the RCMP's response to the mass casualty event, given the barrier that was inexperienced within the area in which the critical incident response was being carried out. The RCMP must be able to adequately train their members without relying on staff turnover to incidentally result in some unspecified and inconsistent experiential learning.

While it is understandable that individuals would certainly have preferences about where they would like to work, it is the RCMP's responsibility as a public servant, as an organization required to provide competent policing services, to ensure it is adequately staffed and providing appropriate compensation, benefits, and supports to do so. However, where it is impractical to do so, the RCMP must nevertheless ensure that it is effectively serving all communities by training its members who are frequently changing locations to understand how to learn about the areas they serve and how to build cultural competency and local knowledge. Our clients submit that the Commission's recommendations must reflect that such efforts must go beyond individual members making singular connections with eager 'community contacts' who may not be inclined to share honest depictions of themselves or their communities.

Interoperability

Training may also be able to address shortcomings in building and maintaining interoperability between the RCMP and other public safety agencies within their various jurisdictions. Naturally, this Commission has focused on relationships between H-Division RCMP and public safety agencies within Nova Scotia, particularly in Colchester County and Halifax Regional Municipality. Our clients submit that the evidentiary record has revealed two significant patterns: firstly, that relationships between H-Division RCMP and municipal policing agencies are broken, possessed of little or no trust or confidence in one another, and secondly, that H-Division RCMP has been openly disinclined to shoulder its share of responsibility for implementing solutions to the various "problems" they identify with other agencies' public safety initiatives. With regard to relationships between the RCMP and other policing agencies, our clients took note of C/Supt. Chris Leather's apparent attitude towards Truro Police Chief Dave MacNeil, and of senior RCMP members' descriptions of Halifax Regional Police Chief Dan Kinsella in the Wellness Report, and most notably, of the RCMP's failure to take advantage of resources offered by municipal agencies both during and following the mass casualty event, among other examples. With regard to

'passing the buck' on public safety initiatives, our clients point to some RCMP witnesses expressing the view that public alerting should not be used until some other agency creates and implements a public education campaign, while overlooking that the RCMP had not undertaken its own education initiatives, as well as C/Supt. Leather's decision that the RCMP would refuse to participate in audits until policing standards were revamped to their satisfaction.

While training is not a complete solution to these specific situations, our clients submit that some training is required to avoid the development of future relationship breakdowns and to actually build interoperability between public safety agencies. Recommendations should ensure that constructive interactions with other agencies and development of positive professional relationships are a core competency for RCMP members, and offer actionable recommendations to encourage the beginning of an effective dialogue between these policing agencies. Further, policies and procedures should be developed so that members can understand what is expected from their interactions with other agencies, and can easily determine whom/which roles members ought to contact from other policing agencies for which purposes. Our clients submit that such recommendations, giving direction as to how the RCMP can better work with local policing agencies, must be made to ensure that interoperability is not dependent on the right individuals occupying the right roles at the right time – recommendations must reflect that all RCMP members should understand how to, and can, work effectively with other policing agencies.

Further, our clients submit that training, rehearsal or practice, is the obvious answer to developing actual interoperability with other policing and related-agencies, whether that be broader focus on interoperability (such as municipal policing agencies practicing critical incident responses together) or more granular interoperability skill enhancement such as policing agencies engaging in TMR2 radio practice with the Emergency Management Office.

Another issue under the heading of "interoperability" is communication and sharing of information between policing agencies and the Canada Border Services Agency.

Our clients submit that significant attention needs to be paid to the interplay between agencies. It is reasonable to assume that, had Canada Border Services Agency's records been integrated with, or informed by, records available to the RCMP (convictions, safety bulletins, reports, complaints, etc.), the perpetrator would have garnered more scrutiny at the border and possibly would have been unable to smuggle weapons into Canada, the weapons he ultimately used to take the lives that he did on April 18 and 19, 2020. Our clients submit that this is an area of analysis and recommendations which should feature prominently in the Commission's final report, in the interests of saving lives in the future.

Succession planning

In the same vein as ensuring that interoperability is not dependent on individuals' personal relationships, our clients submit the RCMP should ensure that members entering new roles are enabled to be as effective as their predecessor.

The Commission has heard from C/Supt. Leather that there is a major gap in succession planning within the RCMP, and our clients submit that there cannot but be concern about the number of vacancies and "acting" positions which were in place at the time of the mass casualty event. Our clients submit that the loss of critical knowledge as members move around or change roles, temporarily or permanently, is obvious and in fact manifested itself during the mass casualty event. Members should know and understand the expectation to engage in succession planning and be able to effectively pass knowledge along to their successors as a they transition roles or retire.

Our clients submit that this is critical to ensure that institutional knowledge is preserved and capitalized on, and therefore, recommendations must be made for policies and procedures to be put in place to ensure that the RCMP proactively protects its stability and abilities and avoids creating gaps in its ability to serve communities with un- or under-filled positions or unexpected movement of its members.

Tools

Tools available but not effectively utilized

Over the course of the Commission's work, our clients submit that it clearly emerged that the RCMP considerably underutilizes resources which it has access to, or easily could have access to, which hampered the RCMP's ability to respond as it ought to have during the mass casualty event. Key examples of underutilized tools are mapping, air support, individual member GPS tracking, and Alert Ready. All of these tools were available to the RCMP institutionally during the mass casualty event, but were not able to be used due to technical issues or, our clients submit, due to lack of foresight and initiative.

With regard to mapping, the Commission has been made aware that superior tools such as Pictometry exist. Even without Pictometry, free-to-use digital tools like Google Maps would have depicted relatively recent satellite imagery of any areas which the RCMP may have wanted to view. However, as was heard from S/Sgt. Addie MacCallum, he was not even able to access computers effectively at the Bible Hill detachment. At the command post, those in charge were working from a hand-drawn map. Outdated maps were pulled from walls in a mad scramble for resources. Our clients submit that these barriers are unacceptable – superior technology was available and should have been used, and suggestions that members were unfamiliar or too overwhelmed to collectively determine all and preferable tools is inexcusable.

The Commission heard from Cpl. Tim Mills that the RCMP's own air support was unavailable more often than not – both he and Cst. Milton expressed that they were unsurprised by this being the case in April of 2020.[14] Our clients submit that a satisfactory explanation as to *why* was not provided by any evidence, other than vague comments such as helicopters having stringent maintenance schedules and pilots being sick sometimes – both fair comments but far short of a satisfactory explanation. It begs the question whether maintaining the current arrangement of air support is a worthwhile expense, given that it appears to be unavailable most of the time it is requested. While our clients would not suggest doing away with air support services as a tool of the RCMP, it is plain and obvious that the current arrangement is unreliable. Recommendations must therefore reflect a superior arrangement within the funding available, along with recommendations for a straightforward procedure to follow when the RCMP's own resource is unavailable. If same cannot be achieved, then recommendations must address what alternatives can be instituted.

GPS tracking of individual members, outside of their cruisers, is likewise a technology which is available in some capacity via the GPS built into TMR2 mobile radios. While we heard some suggestion that this GPS technology would not have extensive utility, it was stated in no uncertain terms by Cmdr. Darryl MacDonald that using the TMR2 built in GPS would absolutely be better than nothing,[15] a statement completely in line with common sense, and that he had long called for its adoption. Instead of actual implementation, however, the Commission have heard only that efforts to that end have been made, but not achieved.

Our clients submit that the delay in implementing mobile GPS tracking of individual members is a classic example of the bureaucratic inertia within the RCMP that prevents them from making critical improvements, given it appears that reasoning rests with being unable to come up with the perfect solution. Given that the inability to track members on foot in Portapique was an impairment to a more robust policing response, our clients submit that it is critical that recommendations reflect the need to make use of this available tool immediately.

Modernization

Recommendations must address the underlying cultural causes which have prevented the RCMP from rectifying the above-issues themselves. Below, we identify issues which our clients state fall within two major categories – cultural failings and accountability failings.

---

[14] Mass Casualty Commission Proceedings, May 16, 2022
[15] Mass Casualty Commission Proceedings, June 23, 2022

Cultural failings

Our clients submit that the RCMP's internal cultural failings have become apparent throughout the Commission's work. One such failing is reflected in the RCMP's apparent disinclination to seriously consider and investigate complaints about potential violent offenders, including persons committing or likely to commit domestic violence in general, which manifested in the RCMP's encounters with the perpetrator prior to April of 2020. The Commission heard about the dismissiveness with which past complaints about the perpetrator, such as that of Brenda Forbes, or the "kill a cop" bulletin, were received. In sharp contrast, the Commission bore witness to Cst. Greg Wiley's implicit trust of the perpetrator during his interactions with the perpetrator. The Commission has also heard of thematically related examples, such as that of Susie Butlin, whose initial complaints were received by several of the same members who appear in the narrative of the mass casualty event. Our clients submit that this overarching cultural problem contributed to the perpetrator's ability to "fly under the radar" for years, despite many red flags and reports to police. It appears that witnesses were viewed as unreliable with limited investigation, while the perpetrator was presumptively trusted and believed.

Our clients submit that this apparent lack of trust in the general public also manifested both during and after the mass casualty event, not the least of which was reflected in the RCMP's disregard for the intelligence and support that residents of Portapique (and the broader community) could have provided to the RCMP to enhance or improve the RCMP's ability to respond.

Also problematic, our clients submit, has been the RCMP's apparent attitude of superiority. While this ties in considerably with accountability issues, our clients submit that the evidentiary record is suggestive of the RCMP generally viewing itself as superior to municipal policing agencies, by virtue of being members of a larger, national organization. Our clients submit that this contributed to the RCMP's disinterest in engaging, or even properly informing, its municipal policing partners during the mass casualty event. Furthermore, in spite of the challenges of the scale of the investigation which followed the mass casualty event, again, the evidence supports that the RCMP continued to refuse assistance from municipal policing agencies, which could have provided valuable investigative resources and allowed RCMP members to recover from the initial mass casualty response and build back capacity. When those most affected by the mass casualty event, the public, and the media expressed questions or disappointment with the RCMP's work, our clients submit that they were met with defensiveness rather than humility.

Our clients submit that this defensiveness continued right through the Commission itself, with many RCMP members expressing the common theme that there was 'nothing they would have done differently.' Many of our clients were pleasantly surprised to hear the apology offered by C/Supt. Darren Campbell during his testimony, as it was the first time a

member of RCMP command had offered an apology for their experience and the RCMP's role in it.

Our clients submit that recommendations should encourage the development of an understanding by the RCMP that, to effectively serve the public, it must be able to accept that its responses to critical incidents cannot be completed in a vacuum, and that it cannot be perfect. To offend a grieving public by closing off communications with the public and deigning to take any responsibility for any weaknesses in the RCMP's response is not, our clients submit, the behavior of an organization prioritizing the best interests of the public.

Even further than accepting that it cannot be perfect, our clients submit the RCMP must also be able to take responsibility when their members do something that is clearly wrong. Our clients submit that a culture of silence still exists around police misconduct, as is evident by the response to Csts. Brown and Melanson's actions on April 19, 2020. Any room for understanding the pressure these members may have felt themselves under has been completely negated by refusal to acknowledge that they could or should have done anything differently, by attempts to paint their errors as "textbook." One must question why Csts. Brown and Melanson had such strong expectations from the beginning that they would not be subject to discipline, as is apparent from Cst. Brown's shock and disappointment at a Code of Conduct investigation being initiated against him, or the length of time for various investigations to run their course. Our clients remain incredulous at the sentiment expressed in Cst. Brown's Mass Casualty Commission interview that he had expected a more positive response to his actions at the Onslow Belmont Fire Brigade. It is our submission that this view of what happened at the Onslow Belmont Fire Brigade is clearly reflective of the RCMP's institutional bias in its own favour. Our clients submit that same is particularly manifested in a SIRT investigation which selectively included and excluded evidence to produce an account of events (and thus an investigative result) supportive of the RCMP.

Our clients thus submit that recommendations should therefore encourage realistic self-reflection within the RCMP, both on an individual level and structurally, to mitigate against the institutional attitude of the RCMP and its members always being 'in the right.' It is submitted that recommendations must be made which institute meaningful, objective assessment of the RCMP's activities to ensure that RCMP members and officers are not only open to and accepting of scrutiny and opportunities for actual improvement, but that this institution actually embodies a more modest view of itself and its members and the reality that there is always room for improvement and growth.

Enforcement of firearms legislation

Our clients submit this Commission needs to assess the rigor with which firearms complaints are investigated and with which Canada's existing firearms-related laws and regulations are enforced. As we have previously submitted, there were many red flags

regarding the perpetrator prior to the mass casualty, and a question that arises from those most affected is whether stricter enforcement of our existing laws and search mechanisms available to police have prevented the perpetrator from being armed to enable him to perpetrate the violence that he did.

To the extent that the Commission considers our existing firearms legislation, our clients would submit that the attention this issue requires is not in regulation, but in meaningful enforcement of our laws – as the Commission has learned, none of the perpetrator's firearms were owned legally, which plainly directs the necessary recommendations to how policing agencies like the RCMP ensure that firearms-related laws are abided by. This begins with proper recognition and investigation of allegations of illegal possession.

Accountability failings

The overarching structure of the RCMP lends itself to avoiding accountability. Our client submit that this themed emerge particularly through the testimony of senior RCMP decision-makers, such as Assistant Commissioner Lee Bergerman and Cmmr. Lucki. In particular, Cmmr. Lucki made assertions that previous recommendations were being implemented – but, curiously, she had no ability to describe what steps were being taken, how progress was being tracked, or who specifically was performing those tasks. Cmmr. Lucki was largely unable to provide the Commission with actual knowledge on any practical programs or initiatives within the RCMP, other than to say that many tasks had either been delegated, or were the responsibility of other roles. She was also unable to speak to any reporting or accountability mechanisms which she oversaw. Our clients submit that the picture that has arisen from evidence given to the Commission, from evidence provided by Cmmr. Lucki but also other commanding officers, is a picture of a command structure in the RCMP which directs those beneath in rank to remedy problems, and, at best, assumes those directives are being effectively carried out.

On the other side of the same coin, our clients submit that the evidence of what happened in April of 2020 bears an inability of lower ranks to effectively solve problems or make decisions without the input of their superiors, and this appearing to be accepted practice. One critical example was the 27-minute wait by Cpl. Jennifer Clarke to obtain permission from Lia Scanlan to send a Tweet containing essential information for public safety, which distressing fact is aggravated by the confusion surrounding who was responsible for actually authorizing said Tweet and whether they did so effectively. Our clients further submit that the evidentiary record exemplifies that critical information or requests were passed up the chain of command, such as information about the existence of eye-witnesses or an alternate exit out of Portapique, again seeming to absolve those lower on the chain of responsibility and enabling them to wait passively for someone else to take action.

The ability of the RCMP to effectively understand how and why these accountability failings lead to negative outcomes is hampered by both their ineffective record keeping and

lack of structured, standardized follow-up after incidents worthy of consideration. Our clients submit that same was observed time and time again throughout the Commission's evidence gathering, with numerous instances of records having been lost, purged, or otherwise destroyed, such as some of Cst. Wiley's notebooks disappearing; such as digital files related to the "kill a cop" bulletin being located by complete chance outside of any organized records management system; or such as records which logically should be retrievable (such as text messages between members) reportedly, inexplicably, not existing.

The inability of the RCMP to effectively keep records, to create and inform their members of clear and robust records retention policies, and to enable systematic access to organized records in the future, should be the focus of recommendations by the Commission. Our clients strongly urge that the Commission keep the privacy of individuals, as protected by existing legislation and as informed by the sociological contexts discussed in Phase II, at the forefront of their consideration of any such recommendations. However, our clients submit that public safety demands that certain types of records, such as Officer Safety Bulletins, be retained indefinitely.

From our clients' perspective, the evidence presented to the Commission creates an overall picture of accountability within the RCMP that, in fact, no-one is responsible for anything when a member or officer can 'pass the buck' to someone either higher or lower on the chain of command. Our clients fervently submit that recommendations must ensure that there is clarity around responsibility within the RCMP, about crystallizing expectations for each and everyone's roles and how they must interact with one another – particularly in the context of a critical incident – so that accountability for their actions is not buried in bureaucracy. Some such recommendations, or clients submit, will write themselves (i.e., if a member receives information about a second escape route from Portapique, that they must assume responsibility for ensuring it is heard and acted upon by those in a position to do so).

Culmination of Issues Identified with the RCMP

All of the above begs the question, in our clients' view – is the RCMP performing community policing? Our clients submit that the RCMP must make significant changes to its manner of operation if it expects to retain public support. It must enhance its training to better reflect the realities of the communities it services, and each and every one of its members must be better prepared to put that training or those tools to use at any moment. It must improve upon its interactions and communications with its policing partners and with local communities, particularly in the context of a critical incident when each and every member of the public relying upon the RCMP is at risk. It must adapt to modern society, to current understandings of social issues and better integration with, and trust in, the communities it serves, and it must be accountable to them. The Commission's task of crafting recommendations to achieve these improvements is not insignificant.

Our clients, those "most affected" the mass casualty event, place their faith in the Commission that it will hear what our clients identify as problematic, in these and our other submissions, and create specific recommendations to achieve these necessary improvements to the fullest extent possible. Recommendations must bridge the divide between the RCMP's self-image as a prestigious national organization and its practical responsibility to provide competent policing services in small communities.

However, in the event that the Commissioners determine that the RCMP cannot rectify any of the issues identified, either in whole or in part, our clients also trust that the Commissioners will not shy away from so identifying and turning its attention to alternative policing models which can better meet the needs of our modern society.

RECOMMENDATIONS FOR COMMISSIONS OF INQUIRY

The Commission has reminded participants and the public throughout these proceedings that the record, findings, and public inquiry itself is an iterative process. Our clients submit that, in a larger sense, the conduct of inquiries in general must be an iterative process. Our clients have sought to remind the Commission of its origins, that it was born of their fight to understand what happened to them and to their loved ones during the depths of their grief. To that end, our clients hope that the Commission has recognized that it, too, has played a role in the support that our society provides to victims of crime, and cannot exclude itself from an examination of what can be done better for those we have lost, and those "most affected" who remain, for the future. There are procedural, structural, and philosophical lessons to be learned from the Commission's work that can and should be applied to future Canadian inquiries.

Those "most affected"

Our clients submit that a commission of inquiry into a tragedy such as the mass casualty event must look to those most affected as the rudder, guiding the decisions made throughout proceedings. Our clients submit that at times these proceedings became somewhat rudderless, removed from a focus on those who fought to make this Commission happen and for whom the ultimate findings of fact and recommendations carry an impact unmatched in the wider public. While our clients are aware of the Commission's mandate, and the Commissioners' obligation to conduct a public inquiry that met the task, our clients submit that the Commission too frequently strayed away from executing its mandate with our clients – with learning about what happened to them and their loved ones – at the forefront.

There is no question that the evidentiary record, and the recommendations that flow from it, is more fulsome and useful because there was a public inquiry into the mass casualty event instead of the originally proposed independent review. There is also no question that the public inquiry happened because of the tireless efforts of the victims' families and those most affected. At times throughout these proceedings, however, those same people became

disenfranchised, some irreparably so. Though this was caused by several issues, the concerns we discuss herein were their differential treatment and issues with meaningful participation.

Regarding differential treatment, and as stated in our oral submissions, our clients feel that at times the "*trauma informed*" lens has not applied to them in the same manner as other participants. Flexibility and leniency was given to witnesses providing testimony that was not similarly enjoyed by our clients. Attention to our clients individual needs was not consistently given. More specific examples of disregard for our clients' particular needs and the failure to apply the trauma-informed lens equally to them are available, as well, such as the Commission's public silence about Heather O'Brien's FitBit data followed by its silence when the O'Brien family was maligned by the National Police Federation for publicly sharing that FitBit data, or when James Lockyer labelled our clients as having "*conspiracy theorist goals*" comparable to the type that have arisen in response to mass casualty events "*south of the border*"[16] simply for opposing the Commission's insulation of the most central witness to what happened in April of 2020.

A very recent example of this issue arose during the Small Group Sessions, in which we, as our clients' counsel, were repeatedly told that our participation was not anticipated – later, that we could attend to support our clients, but could have no speaking role. Space was set up for these sessions to separate counsel from clients (though it is acknowledged that our clients' rearrangement of the space was not opposed). Our clients feel that treatment was significantly different from the treatment of those interviewed throughout the Commission, who had counsel attending and participating with the provision of evidence. Though we appreciate the small group sessions were not interviews in the same way as those conducted by the Commission with, for example, RCMP members, they were still recorded meetings that will form part of the Commission's evidentiary record. As such, our clients feel that it was inappropriate to attempt to limit these participants' access to counsel.

The recommendations our clients submit should flow from the above, imbue future such commissions of inquiry, is simply stated: the interests of those most affected must be a primary guide in decisions related to the conduct and goals of a public inquiry, at all times.

At various stages, a number of our clients have expressed concern about the way they were treated and spoken to by a member of Commission Counsel throughout these proceedings. Those clients described experiencing a lack of care and compassion, at times confrontation in meetings and dismissing of concerns of participants, and in one instance storming out of a meeting with an upset family member. Those of our client group who have commented, both to us and to the Commission itself, described having felt "handled," treated by this

---

[16] CTV News, July 14, 2022: <Lisa Banfield's lawyer explains why she shouldn't be cross examined | CTV News>

individual as though they (and their counsel) were a nuisance – irritants to be endured in the process. That the Commission was aware of many of these negative encounters and appeared to not address them was disappointing to our clients – and, further, to appoint that member of Commission Counsel to represent the Commission in the barrier that it put up between our clients and a critical witness was, in our clients' view, trauma-inducing to them for the sake of another.

It goes without saying that no person who has experienced what our clients have should be further affronted by those tasked with conducting the related commission of inquiry.

We would pause to stress that our clients, as well as ourselves, have had many positive experiences with Commission Counsel and Commission staff, and many of these individuals should be commended for their compassion, hard work, and tireless efforts throughout (though certainly not a closed list, notable examples include Jenalee Patterson, Darlene Sutherland, and Maureen Wheller).

Care must be taken in future inquiries when dealing with traumatized individuals. Our clients seek a recommendation reflecting that, in future, those tasked with dealing directly with victims and their families receive specific training and standards on this point to ensure an appropriate level of understanding and management of high stakes emotional proceedings for all "most affected," at all times.

The evidentiary record

Though the Commission was not an adversarial process, the wisdom of our country's highest courts must still influence the conduct of Canadian commissions of inquiry. To this point, it has been commonly held that the most effective tool at getting to truth is full and robust cross-examination. However, throughout these proceedings that maxim has taken a back seat to the Commission's unevenly applied (and at times under-explained) trauma-informed mandate.

Though our clients would agree that there are instances in which a commission of inquiry must adjust the procedure for getting evidence to offset the risk of trauma to the witness, we recommend this must be considered in the context of that witness and the import of their evidence. Further, participants must be provided fulsome justifications for accommodations. In our clients view, the Commission failed to always meet these standards, most critically, in the case of the Commission's choices for handling of key witnesses like Lisa Banfield and Cpl. Rodney Peterson, but also in the way requests for accommodations were managed and decided, such as in the cases of S/Sgt. Rehill and Sgt. O'Brien.

Though the Commissioners claimed in their decision dated July 14, 2022[17] that it was incorrect for our firm to assert that no basis was offered to justify excluding cross-examination by participant counsel of Ms. Banfield, our clients feel they have yet to receive an answer to the question: what problem was addressed, or what mischief was sought to be avoided, by preventing involvement of participant counsel in cross-examinations? Without this explanation, our clients cannot but feel that the apparent answer is that participant counsel could not be trusted to examine Ms. Banfield in an appropriate manner – fueling speculation that we or our clients would seek to attack the witness or promote "*conspiracy theories*."

Again, we and our clients understand the Commission's process is not an adversarial one. However, our clients submit that to limit not only participation, but explanations about those limitations, smacked of distrust and, ironically, incubated an adversarial atmosphere. Just as concernedly, however, our clients submit that the Commission's essentially closed door and controlled approach to drawing out Ms. Banfield's evidence has allowed that evidence to forever remain vulnerable to skepticism and doubt. The same may be said of witnesses like S/Sgt. Rehill and Sgt. O'Brien. Future commissions of inquiry employing less traditional evidentiary procedures under a trauma-informed lens must take care to strike a more transparent and effective balancing of interests to ensure that the harm caused to our clients, and the vulnerabilities imposed upon evidence like Ms. Banfield's, does not occur again. Our clients wish to see recommendations which provide this direction for future commissions of inquiry of this nature.

Distinct, but not wholly unrelated, is our clients' concern about the manner in which the Commission presented its work – namely, its Foundational Documents – in public proceedings. Our clients submit that care must be taken in future commissions of inquiry to ensure matters which are obviously fundamentally important to those most affected be provided adequate time and attention in public proceedings – not just for the sake of those "most affected," but for the sake of the integrity of the exercise as a whole. The Commissioners will have heard, including in recent small group sessions, that a number of the Foundation Document presentations were offensively short (specific examples include the presentation of the "2328 Hunter Road" and "Plains Road, Debert" Foundational Documents). This is an especially important critique to bear when considering the relatively trivial presentation of deeply affecting subject matter that is the exact reason this Commission exists against the inordinate attention provided tangential topics in Phase II.

We understand that some of these decisions were likely made to limit the participant's trauma, to protect the dignity of them, their families and the loved ones they lost. However, the Commissioners will have heard our clients' expression of frustration with

[17] "Decision Regarding July 11, 2022 Participant Motion", July 14, 2022.

seemingly paternalistic decisions made about what they could handle and how they could handle it, without any consultation with them. Future commissions of inquiry, our clients submit, must recognize participants such as our clients as adults, capable of recognizing their own needs and limitations – capable of deciding what will and will not traumatize them – so as to avoid other participants "most affected" from feeling infantilized by a process created, at their insistence, for the purpose of answering their hard questions.

Concerns with Phase II

As stated in oral submissions, our clients recognize that the Commission does not have control over what issues are included in its mandate. However, how these subjects are approached, with what academic resources they are addressed, and how much time is dedicated to exploring certain areas was well within the control of the Commission. To this end, at times, our clients felt that the Commission again became rudderless, seemingly drawn into deep exploration of specific social issues with speakers given insufficient direction to ensure relevance between the discussion and the goals mandated for this Commission. We have already identified in our oral submissions that our clients are not alone in this critique, having pointed the Commission to public statements of confusion and criticism by deeply respected scholars such as Professors Wayne MacKay and Ed Ratushny.

Again, we stress that our and our clients' position is that all topics discussed throughout Phase II are important and worthy of attention, though not all within the work of the Commission. The Commission repeatedly referenced its tight timeframe and making decisions about how to handle what evidence based on an inability to do it all within public proceedings, and witnesses were not called before public proceedings for that very reason. Proceedings days became uncontrolled in their breaks and end times, without the option of having witnesses return another day to complete their evidence when they and counsel questioning them would be fresh (and not burdened by the strain of having other time considerations and commitments), which was also a problem for participants and others wishing to observe proceedings. At the same time, an inordinate amount of time was devoted to "Phase II" discussions, whether directly or indirectly relevant, or seemingly not at all. Our clients submit that the ways in which the Commission addressed these mandated issues and the time dedicated to those analyses was untethered from the experiences of the victims and the constraints of the process. At times, the lineup of panellists resembled a social-sciences conference, certainly curated for somebody other than our clients.

Our clients submit that this resulted in missed opportunities to explore topics directly impacting those persons most affected. A notable example is, as discussed previously, the physical displacement of residents by trauma, and means to support their relocation to minimize ongoing pain and suffering.

It is notable that this relevant subject area was brought before the Commission partly because Ms. Colpitts urged the Commission to come and interview her. The same may be said of others in circumstances comparable to hers, or the circumstances of those who remained in Portapique. Our clients submit that it was a missed opportunity for the Commission not to explore the topic of physical displacement of surviving victims, and other topic areas that those surviving victims would have identified as priorities to them. This example shows, in our clients' view, the pitfall into which the Commission fell by focusing too intently on its mandate, and not properly attending to the individual experiences and needs of those "most affected."

On this topic, while it may be too late to devote more time and attention directly to those "most affected," it is not too late to address the hardships our clients have endured, and how they may be rectified in the future. Future commissions of inquiry can learn from this oversight, this failure to learn from the victims of the very event being examined, can ensure a better complement between a mandate and those it is struck for. Our clients ask that same be reflected in the final report's recommendations.

Accountability in Inquiry

As provided in our oral submissions, our clients submit that this Commission must not shy away from assigning accountability for fear that same will resembles blame. As was true in the public inquiry into the Westray Mine disaster, this Commission must "*name names and assign accountability*"[18] if its recommendations are to be meaningful and impactful. This, and all future commissions of inquiry, must have teeth or else the recommendations are at risk of being shelved.

Accountability is not just something to be applied in assessing the subject of an inquiry, but in addressing transgressions in conduct *during* an inquiry. Of specific import is — as Ben Perryman described in oral submissions on September 23, 2022 — the Department of Justice of Canada's *"lethargic"* approach to disclosure. As touched upon in our oral remarks, throughout the Commission's work, our clients submit that the Commission has witnessed concerning evidentiary contributions (or lack thereof), such as the unexplained withholding crucial pages of Chief Supt. Campbell's handwritten notes for months (under the auspices of needing to vet them for privilege), or the release of relevant documents either during, or in some cases after, the respective witness' live testimony (e.g., information pertaining to the infamous April 28, 2020, meeting was disclosed after Lia Scanlan appearing as witness). As late as today, we have been provided with extensive and relevant disclosure from the Department of Justice of Canada, all of which cannot be reviewed and included in our submissions.

---

[18] CTV News, "Murphy's Logic: <OPINION: Murphy's Logic - Put facts over feelings | CTV News>

Possibly the most problematic example of this came when Chief Supt. Leather waived solicitor-client privilege during public proceedings to inform the Commission that he was advised by counsel for the Department of Justice of Canada to take a "*reactive*" approach when he specifically inquired about proactively disclosing highly relevant facts and events.[19] Chief Supt. Leather was clearly alive to this being problematic advice, considering he sought independent counsel on the same point.

These issues – even if plausible explanations are belatedly given by the Department of Justice of Canada – compromise the integrity of the Commission's evidentiary record. Quite simply, our clients submit that if they have reason to distrust that complete and transparent disclosure has been made to the Commission by the holders of information on behalf of the RCMP, then they – and the public – will struggle to trust the findings made by the Commission.

Our clients submit that, in the theme of "accountability," Commissioners must specifically address these evidentiary issues in their final report, such that this approach to disclosure as has been seen from the Department of Justice of Canada is not encouraged in future commissions of inquiry. Our clients further recommend that procedures and tools be instituted in future inquiries, including earlier exercise of subpoenas, enforcement of timelines to respond and tools similar to costs awards in civil proceedings, which could help to prevent disclosure practices that undermine and/or delay commissions of inquiry.

CONCLUSION

Our clients' hopes for this Commission's final report are extremely high. We, along with our clients, recognize the enormity of the Commission's task, but must also remind of the enormity of the loss that brought it about. Our clients expect a comprehensive final report which, to the fullest extent possible, honours our clients, their loved ones and their suffering, and ensure that positive change comes from the heavy, hard work that has been done here.

[19] Mass Casualty Commission Proceedings, July 28, 2022.

ALL OF WHICH IS RESPECTFULLY SUBMITTED this 7th day of October, 2022.

Respectfully,

Sandra L. McCulloch
smcculloch@pattersonlaw.ca
Tel: 902.896.6114

Grace A. MacCormick
gmaccormick@pattersonlaw.ca
902.896.6197

Matthew G. MacLellan
mmaclellan@pattersonlaw.ca
Tel: 902.405.8125

Natasha M. Schigas
nschigas@pattersonlaw.ca
902.600.9521

SLM/GAM/MGM/NMS/

c. R. Pineo/M. Scott
Clients