Via Email: participation@masscasualtycommission.ca

October 12, 2022

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Dear Commission Counsel:

Re: Final Submissions

Introduction

This is the final written submission on behalf of our clients, the family of Aaron Tuck, Jolene Oliver, Emily Tuck, and the family of Lillian Campbell.

On April 18 and 19, 2020 Gabriel Wortman murdered Tom Bagley, Kristen Beaton, who was expecting a child, Greg and Jamie Blair, Joy and Peter Bond, Lillian Campbell, Corrie Ellison, Gina Goulet, Dawn and Frank Gulenchyn, Alanna Jenkins and Sean MacLeod, Lisa McCully, Heather O'Brien, Jolene Oliver, Aaron Tuck and Emily Tuck, Constable Heidi Stevenson, Joanne Thomas and John Zahl and Joey Webber.

We have remembered them each and every day of the public proceedings of the Mass Casualty Commission. We have kept them, their families and loved ones and others directly affected by the mass casualty, including Andrew MacDonald and Constable Chad Morrison who were wounded during the event, close in our thoughts throughout the course of this public inquiry.

It is our hope that the final report of the Commissioners will honour the memory of and be a lasting legacy for those whose lives were so tragically lost in Portapique, in Wentworth, in Debert, and at two locations in Shubenacadie, on that terrible weekend in April of 2020.

Definitions

In this submission, the following definitions/abbreviations are used:

a. "April 18" means April 18, 2020;
b. "April 19" means April 19, 2020;
c. "ERT" means Emergency Response Team
d. "IARD" means Immediate Action Rapid Deployment

e. "MC" means the mass casualty event from approx. 10 pm April 18 to 11:30 am April 19;
f. "MCC" means the Mass Casualty Commission;
g. "OCC" means Operational Communications Centre
h. "perpetrator" means Gabriel Wortman
i. "the inquiry" means the public inquiry conducted by the Mass Casualty Commission;

Overview

In our submission we will:

1) provide a brief summary of the facts, as we accept them to be, based on the evidence brought out through the Foundational Documents and testimony before the inquiry;

2) discuss the key issues arising from the mass casualty specific to our clients;

3) identify and discuss key issues of general application;

4) inquiry process; and

5) set out our suggestions for recommendations in some of these areas.

1. Factual Understanding of Events on April 18 and 19, 2020

In this section we will comment on some of the key factual underpinnings of the mass casualty event on April 18 and April 19, 2020. We will not deal with the entire MC event but rather will focus on the fact scenarios most germane to our clients.

Activities on April 18 prior to the MC

Lisa Banfield provided statements to police, to the MCC and gave testimony in person before the inquiry. Information from her various interviews includes her account of the activities of her and the perpetrator during the daytime and early evening hours of April 18.

The information from Ms. Banfield includes that she and the perpetrator had Face Time calls with their friends, Sean Conlogue and Angelette Patterson who lived in or near Houlton, Maine, USA during the evening of April 18 while having drinks to celebrate their nineteenth anniversary at the warehouse on Orchard Beach Drive.[1]

[1] P-000003(COMM0050893) Portapique: April 18-19,2020 Foundational Document, para 62

The final call was the one with Ms. Patterson during which she apparently discouraged the perpetrator from having a "commitment ceremony" on their twentieth anniversary in 2021. It was this comment which Ms. Banfield has said upset her and led to her ending the call, having words with the perpetrator, and then leaving the warehouse to go back to the cottage. She then returned briefly to the warehouse where she says she found the perpetrator "in a rage". They argued, she left again, returned to the cottage, and went to bed.[2]

After what Ms. Banfield describes as a short time, the perpetrator came back to the cottage, dragged her from bed, assaulted her, restrained her with a bathrobe belt around her wrist and they left the cottage as he lit the gasoline he had already poured throughout the building. He was armed with a pistol. They proceeded back to the warehouse with her struggling and attempting to escape which she did after he locked her in the replica police car and went upstairs in the warehouse. Ms. Banfield says she ran into the woods and hid until she ventured out in the early hours of the next morning. She went to the home of Leon Joudrey who called 911. Members of the ERT team picked her up there and transported her first to the EHS ambulance staged in Great Village and later to the hospital. She provided information to the police at this time including details of the replica police car.[3]

After reading the various statements and witness testimony of Ms. Banfield it does not appear that she was ever pinned down on a timeline for when those various calls, in particular when the call with Ms. Patterson, ended. Ms. Patterson, in the Statement she gave to Sgt. Dave Legge on May 20, 2020, put the time as approximately seven-thirtyish her time (Maine).[4]. That would have been approximately 8:30 in Nova Scotia.

This timeline leaves approximately one and a half hours for the events that Ms. Banfield describes as taking place from the time the call with Ms. Patterson ended, leading to her escape into the woods, and when the murderous rampage began with the killing of Greg Blair at roughly 10:00 pm.

We also note here that while initial investigative interviews were conducted with both Sean Conlogue and Angelette Patterson by both RCMP and US authorities, the MCC investigative team was unable to reach them for in-depth interviews. Unfortunately, the MCC's powers of subpoena did not extend to these individuals as residents and citizens of the United States.

We have briefly recapped Ms. Banfield's factual account of the early evening hours of April 18 for context but neither accept nor contest her account of what took place. This position is due to our dissatisfaction with the inability of participants counsel to directly cross examine Ms. Banfield

[2] Ibid, para 63
[3] Ibid, paras 64-67
[4] P-000014 (COMM0012711) Statement of Angel Patterson, line 1090

when she testified at the inquiry. While we did submit questions for commission counsel to pose to Ms. Banfield, we do not consider that format to have been an acceptable substitute for testing the evidence of such a crucial witness through direct questioning by participant counsel.

MC April 18 – 19

The first 911 call was from Jamie Blair at 10:01 pm April 18. That call reported the first victim of the carnage that began in Portapique that night and continued the next day on Hunter Road and Highway 4 in Wentworth, on Plains Road, Debert, at the Shubenacadie Cloverleaf and finally to the residence of Gina Goulet on Highway 224 in Shubenacadie.

We note here that we agree with the hypothesis that the perpetrator used the road along the blueberry field as his exit route out of Portapique the night of April 18 and the timeline developed for that exit, being approximately 10:40 – 10:45 pm.

Evidence of what happened on Cobequid Court April 18

A few comments on the evidentiary record and timeline applicable to the murders of our client's family members in their home on Cobequid Court on the night of April 18, 2020.

There is no evidence before the Commission that allows for a definitive conclusion as to the precise circumstances and timing of the deaths of Aaron Tuck, Jolene Oliver, and Emily Tuck. In the course of this inquiry, the MCC investigators gathered evidence and supporting information for two possible hypotheses.

One being that the perpetrator may have gone to Cobequid Court after leaving the Blair residence on Orchard Beach Drive at which time he murdered Aaron Tuck, Jolene Oliver, and Emily Tuck, as well as Joy and Peter Bond who also lived on Cobequid Court. If this was the scenario, it likely occurred between 10:05 and10:15 pm. This accords with information that Emily Tuck had been texting with a friend that evening and was not heard from after 10:03 pm.

This theory was based on information that Lisa McCully's cell phone data put her outside her residence between 10:13 and 10:16 pm so that her death would have occurred during that time frame. That would have meant the perpetrator had time to travel to Cobequid Court after leaving the Blair residence and be back on Orchard Beach Drive by 10:13 pm in order to murder Ms. McCully when she was out in the front yard of her residence.

The alternative theory was that it happened in reverse order. That creates a gap in his movements between the time he left the Blair residence and when he shot Ms. McCully and then presumably when to Cobequid Court according to that theory.

However, new information came to light after the first two theories were explored and discussed in the Foundational Document, Portapique: April 18-19,2020. That new information is set out in the Addendum and Erratum to the Portapique Foundational Document. It says that further investigation of Ms. McCully's cell phone data now supports that it is likely she was outside her residence around 10:08:15 pm meaning her death would have occurred prior to 10:13 p.m. This now makes it more plausible that she encountered the perpetrator immediately after he left the Blair residence and before he went to Cobequid Court.[5]

We will never know for certain. Either scenario would result in a conclusion that Aaron, Jolene, and Emily's deaths likely occurred between 10:05 and 10:20 taking into account more precise timelines for the interactions of the perpetrator with other victims and at other locations in Portapique after 10:20 pm.

Sadly, while most of the crime scenes were discovered in a relatively short time frame, the two scenes on Cobequid Court would go undetected for nearly 19 hours before police finally acted on reports that the residents there were unaccounted for.

Evidence of what happened on Highway 4 in Wentworth April 19

On Sunday, April 19, Lillian Campbell left her home on Highway 246 for her daily walk some time between 9:02 a.m. and 9:12 a.m. Neither Lillian Campbell nor her husband had any awareness of what had happened in Portapique the night before.

Ms. Campbell walked from her home to the intersection of Highway 4 and 246 and it is believed, and accords with what happened, that she turned left onto Highway 4 heading south. Her husband, Michael was expecting her back between 10:30 and 11:00 a.m. as she usually walked for 1.5 to 2 hours per day. She did not return.

Mary-Ann Jay lives on Highway 4 a short distance from the intersection of it and Highway 246. She heard a gunshot sometime around 9:30 am. She looked out her window and reported seeing an RCMP car "slowly turning around and heading south, toward Truro." Mrs. Jay then saw a body lying on the side of the highway. She recognized the person as her neighbour, Lillian Campbell based on the person's clothing. Mrs. Jay ran outside and checked on Lillian Campbell and believing she was deceased, ran back inside, and called 911. The time of the 911 call was 9:35:35 am. [6]

[5] P-005480 (COMM0064786) Addendum and Erratum to Portapique: April 18-19,2020, pg 3
[6] P-000334 (COMM0053597) paras 20-22

We note here that the canvas for video surveillance has established a timeline for movements of the perpetrator as he left Hunter Road, approximately 9:23:29 and then drove south on Highway 4 passing by the Wentworth Market at 9:29:50 am, just prior to the shooting of Lillian Campbell at approximately 9:30 am. However, the statement given by Reginald Jay, husband of Mary-Ann Jay, provides information that conflicts with the timeline supported by the video surveillance. Mr. Jay, who was unaware of the events in Portapique, had been out and about in the Wentworth area as early as 9:00 am checking on seasonal properties that he monitored for the owners. He stated that at approximately 9:05 am he observed an RCMP vehicle with a "push bumper" on the front of it sitting at the junction of Highways 4 and 307, north of both the Wentworth Market and intersection of Highways 4 and 246. He states it was still there when he went by again approximately 5 minutes later.[7] Mr. Jay was not called to testify on this issue, and it appears this discrepancy is not able to be resolved on the evidence.

All other events, locations, and timelines

In respect of the facts surrounding the movements of the perpetrator around the community of Portapique before leaving the area, the likely sequence of the killing of the other victims in the community, the shooting of Andrew MacDonald, the arrival of the first four RCMP members and essentially all that flowed from that point on in Portapique, and all the subsequent locations and events, we take no serious issue with, and generally are in agreement with information as to what happened, where it happened and the timelines of events as set out in the evidentiary record of the inquiry whether provided in Foundational Documents tendered into evidence or provided through viva voce evidence from witnesses who testified before the inquiry.

2. Key Issues Specific to our Clients' Families

Family of Lillian Campbell:

i) Alert Ready

Lillian Campbell left her home between 9:02 and 9:12 am on April 19. In the time before she left her home, the television was on, the computer was on, and their cell phones were turned on. She did not take her cell phone with her when she left for her walk. She was murdered sometime around 9:30 am.

Lillian and her husband, Michael Hyslop were not Twitter users. Twitter was the only communication method used by the RCMP to send any messages to the public during the MC. We

[7] Ibid, at paras 17-18

acknowledge that the RCMP was preparing to send an Alert Ready late in the morning on April 19, approximately 11:21 am, but before it could go out the perpetrator was killed shortly after 11:25 a.m. [8]

The RCMP did too little, too late about issuing an Alert Ready warning. By the time the use of Alert Ready was approved it was too late to make a difference for any of the victims it might have alerted, including Lillian Campbell or members of the general public who otherwise were unaware of an active shooter on the move the morning of April 19.

The evidence from numerous RCMP members, including some of the highest-ranking members in H Division at the time, was that they had no awareness at all of Alert Ready, what it could do and that it could be used to alert the public of the situation was incredulous. This was despite the evidence contained in the Alert Ready in Nova Scotia Foundational Document, COMM0057390, of multiple occasions from as early as 2010 that representatives of the RCMP attended meetings and presentations on the public alerting system being rolled out in Nova Scotia.

Perhaps the most compelling piece of information is the briefing note of then Staff Sergeant Mark Furey dated January 4, 2012, to the RCMP Criminal Operations support services officer regarding the public alerting system.[9]

We acknowledge the efforts and steps that have been taken in the past 28 months by the RCMP to set up internal policies, procedures, and training for the use of Alert Ready. The use of this system just a short time ago during the horrific mass casualty event in Saskatchewan demonstrates a lesson was learned from the MC in Nova Scotia. This is a positive step in the right direction.

However, as we heard from various sources during roundtable discussions and from witness Michael Hallowes and his presentation on public warning systems, public education on what to do and perhaps more importantly, what not to do, when a public alert is sent out is a key component. That is the way to guard against the concerns for things like overwhelming the 911 system with people calling for direction. To date we are not aware of any public education campaign having been undertaken in this country about the National Alert Aggregation and Dissemination System (NAAD) which is the system supporting delivery of an Alert Ready public warning.

The evidence and discussions during the inquiry focused a lot on the failure of the RCMP to issue an Alert Ready notice to alert the public about the active shooter event. The reliance of the RCMP on social media messaging, specifically Twitter, also came under criticism for a variety of reasons including the demographics of the population in the largely rural area immediately at risk as being a population unlikely to follow social media at all let alone Twitter specifically.

[8] P-002001 (COMM0058836) RCMP Public Communications, April 18-19,2020, at paras 142-147
[9] P-001254 (COMM0057390) Alert Ready in Nova Scotia, para 9

We suggest that criticism is justified and should be addressed by H-Division RCMP here in Nova Scotia. Modern public communications strategies should of course include social media platforms, but we suggest they should not do so to the exclusion of other, more traditional public communication tools that still have relevance today, especially in rural areas. People still listen to local radio stations, they watch local, provincial based newscasts on television.

When it is necessary to communicate important information, especially where there is a real risk to the safety of the general public in Nova Scotia, whether province wide or in a specific location, and the situation does not meet the criteria for an Alert Ready message, the RCMP strategic communications officers should not discount the value of issuing an urgent news release to radio and television stations for immediate broadcast including requests that regular programming be interrupted to air that release. When there is a situation where the RCMP or other policing agency has a duty to warn the public, in our view the police service involved does not fulfil that obligation by relying on the "traditional media" to re-post or otherwise disseminate their tweets or other social media postings as we heard about during testimony before the inquiry.

The reality is that while the ways and means of communicating news and information has evolved exponentially in today's world, the entire population of this province, nor any other, has not and for many reasons. Those people can not, should not, must not be missed in a crisis. The extra effort of using more than one method of communicating public safety information to the general public has to be taken in the future. It could save a life to do so and sadly, could cost a life if not done.

Recommendation #1

We request that the Commissioners recommend that the federal government task its Department of Public Safety and Emergency Preparedness and the Alert Ready service provider, Pelmorex, to immediately develop and implement a national public education campaign on the public warning system, Alert Ready.

Recommendation #2

We request that the Commissioners recommend that the RCMP, on a national level, review all strategic communications policies and procedures and revise them as necessary to mandate that all communications to the general public that are for the purpose of warning of immediate situations that pose a risk to public safety, but for which an Alert Ready warning is not being issued, be released to traditional media outlets, such as print media, radio and television as well as appropriate social media platforms and that this be undertaken immediately with implementation of new policies and procedures within six months.

ii) Air Support

It is perplexing and seriously concerning that as this tragedy was unfolding in Portapique, the RCMP in Nova Scotia were unaware that the RCMP Atlantic air support services out of Moncton were not available. It was only at approximately 11:16 p.m. on April 18, that RCMP Risk Manager, S/Sgt. Brian Rehill was informed there was no air support available.

An RCMP helicopter with the ability to fly at night, equipped with thermal imaging cameras, would have been of great assistance as this would assist in locating the perpetrator, or if not him, then at least Ms. Banfield hiding in the woods. The general duty members on scene recognized that the helicopter could be of great assistance and called for air support as early as 11:42 pm but were told it was unavailable.[10]

The timely involvement of properly equipped air support could conceivably have changed the course of the MC event in any number of ways. For example, we will never know if early use of appropriate air support for the situation at hand could have prevented the loss of Lillian Campbell's life.

Special Constable Larry Labadie, the RCMP helicopter pilot in Moncton, with 42 years experience, gave a statement to the Commission. Constable Labadie believed the RCMP aircraft would have given the RCMP a good chance to catch the perpetrator because of its technical capabilities. He advised that response time from emergency calls to airborne aircraft typically, is 45 minutes. Flight time from Moncton to Portapique is approximately 40-45 minutes at 112km/60nm – distances as the crow flies. If an aircraft had been available, he estimated he would have been orbiting Portapique by approximately 00:30 hrs (April 19, 2020), and that the weather and environment was very favourable for this mission request.[11]

H- Division had no established plan B in place for air support.

Responding officers, on all levels, were inquiring as to the availability of air support. Throughout the night and into the morning of April 19th, the phone calls and emails started in an attempt to locate and secure alternative air support.

Calls and emails were made to the Joint Rescue Coordination Centre (Search and Rescue), Transport Canada, Department of Natural Resources (DNR), RCMP Air Services Ottawa, and at 11:13 a.m. on April 19, 2020, Chief Super Intendent, Chris Leather reached out by email to Major

[10] P-002042 (COMM0058856) Air Support, para 65
[11] P-002045 (COMM0058846) Investigations Supplementary Report-RCMP Air Support Assets, pg.8

Garrett Hallman of the Canadian Armed Forces. Major Hallman indicated he would quickly advance requests for "any CAF resources."

As we know, a DNR helicopter was located and was in the air on the morning of April 19, 2020, for "evacuation purposes". It could only fly in daylight hours and at higher altitudes. It could not fly into "hot zones." It was not equipped with FLIR and had communication issues.

Valuable time and recourses were used to try to secure air support. These tasks likely factored into the communication delays we have so often heard about in the evidence and unfortunately contributed to the tragic outcomes.

It appears RCMP H-Division may have addressed the Air Support issue, including clearly established alternatives to the use of the existing RCMP aircraft assets in the Atlantic Region. However, we are not certain of this or that it is sufficient.

Ideally, in our opinion, H-Division should have its own air support asset, preferably a helicopter, equipped to the same level as the one currently stationed in Moncton. We recognize that the cost of this is great but with the past and current issues around the existing level of air support in the Atlantic region, including frequently being out of service, as became clear from the evidence before the inquiry, we believe there is a strong case to be made for more aircraft availability to service the Atlantic region. It is not clear that looking for alternative sources of aircraft from other agencies within the Atlantic region is the answer. That is because when that exercise was carried out during the MC event, obstacles such as restrictions on flying at night or into "hot zones" (like an active shooter situation" as well as lack of necessary equipment such as FLIR, where impediments to engaging assets from other agencies such as the Joint Rescue Coordination Centre and Department of Natural Resources and Renewables (DNR). Alternative RCMP assets from other Divisions outside the Atlantic region are clearly inadequate for immediate and ongoing active situations like the MC event due to their response time based on distance.

Recommendation #3

We urge the Commissioners to recommend that the federal government provide funding to the RCMP for the purpose of adding one additional helicopter, fully equipped for policing activities, to the Atlantic region air support and ideally that it be stationed in H-Division but if logistical reasons or staffing and maintenance issues make more reasonable to do so, then add it to the assets currently located at J-Division in Moncton, NB.

While we recognize this is a costly recommendation, in our view it is justified on the evidence before the inquiry about the history of air support issues and it is necessary to provide a proper level of service to the members of the public residing the Atlantic region of the country.

iii) Roadblocks/Checkpoints

At one point during the early hours of April 19, it was surmised that the perpetrator may be headed to New Brunswick, where his parents lived. The RCMP directed an officer to the Cobequid Pass Toll Facility on the Trans Canada 104 Highway which is one possible route from Portapique to New Brunswick. The officer directed to the toll booth area to watch for vehicles connected to the perpetrator was set up there between 12:03 a.m. and 9:45 am at which point she was redirected to respond to Lillian Campbell's scene. This was apparently not an actual checkpoint but for observation purposes. The location of Lillian Campbell's murder was the "old Trans Canada" highway, Highway #4, which is also a possible route to New Brunswick. The highway is well known by locals and travellers. No observation points, checkpoints or roadblocks were set up on Highway 4.

Recommendation 3.6 from the Moncton Inquiry[12] called for a policy and protocol, through an emergency operational plan, to identify entry/exit points and major transportation routes that should be alerted and monitored in the event of a relevant crisis.

It appears RCMP H-Division had this policy on the books, but it was not implemented on April 18/19, 2020. It is not sufficient to have policies and procedures in place if they are not followed.

iv) Next of Kin Notification

Michael Hyslop was not expecting Lillian Campbell to be back from her walk until between 10:30 and 11:00 am. as she usually walked for 1.5 to 2 hours per day. Michael received a telephone call from his stepmother before he would have expected Lillian to return. He recounts what happened as a result of that phone call as follows[13]:

> *"My stepmother phoned me around 10:45 and asked me if Lillian was with me. I said no she went for her walk up the Valley Road. She told me she heard about some shootings out in west Wentworth and also about a woman being shot in Wentworth and that I should go get Lillian. I left right away and drove from the house to the junction of Highway 246 and Highway 4. There was a large police presence there already and Highway 4 was blocked. Never heard any sirens, had no idea they were there.*
> *I got out of my car as I could see someone lying under a blanket in front of Reg Jay's home and I told an RCMP officer I was looking for my wife who went for her walk but has not come back yet. He just told me to get in my car. I told him again why I was there and also*

[12] P-004497 (COMM0058320) Independent Review Moncton Shooting, June 4, 2014, Page 180
[13] P-000358 (COMM0049611) Responses to MCC Questions from Mr. Hyslop

told him what she was wearing. He then told me to get back in my car and someone would be with me shortly. I waited for maybe 15 - 20 minutes in my car then a gray sedan with 2 officers came down Highway 4 from the West Wentworth direction. They went into the blocked off area and I could see them talking to others. They then drove up to my car and a female officer told me my wife was deceased. I got out of my car, tried standing but found it hard, I remember the officer asking if I had family or relatives close by, I told her my stepmother was close. The 2 officers drove me up to my stepmothers then they departed. I returned to my own home later that afternoon.

- *Late on the afternoon of the 19th, two RCMP Detectives came to our home and offered their condolences and took down Lillian's personal information and a brief statement. They did mention that someone would be in contact with us at some point in the near future.*

- *Received calls from Victim Services and also from the RCMP Major Crime Unit Victim Services in Bible Hill but was not given details on what actually happened, just information on the services they provide. The majority of information received was from various media sources"*

Mr. Hyslop remained in his vehicle for approximately 20 minutes alone, as he was directed. He was able to see a body under a blanket at the side of the road ahead of him. He did not know where his wife was. Imagine if this was happening to you, with your loved one. It was inhumane.

We are not saying the officers' actions were deliberate or planned, but nonetheless were clearly insensitive to Mr. Hyslop in that situation. Whether that scene played out as it did due to a lack of training or plan on how to deal with family members in the aftermath of such an event, especially ones arriving at the actual crime scene or inexperience, it was not the treatment that Mr. Hyslop deserved.

Cst. Harvey was the officer who first spoke to Mr. Hyslop. Cst. Counter was also at the scene. Cst. Harvey's member report explains that he knew S/Sgt. Craig Learning was enroute and so he wanted to wait until more members arrived before notifying Mr. Hyslop of his wife's death.[14] It is not clear why Cst. Harvey felt the need to have more members there before doing the next of kin notification. Whatever those reasons were, they created an unacceptable delay in the circumstances that existed at the time, i.e., Mr. Hyslop reports his wife is unaccounted for, and he is sitting in a car a relatively short distance away from what is obviously a body lying on the side of the road covered by a blanket.

[14] P-002222 (COMM0058972) Information Seeking from Families and Next of Kin Notifications, para 246

Unfortunately, this pattern of behaviour was repeated throughout this tragedy. The next of kin notifications for the Oliver/Tuck family, for Heather O'Brien and Kristen Beaton come to mind.

We have issues on next of kin notifications for our other client family as well and will set out our recommendation on that topic below.

Family of Jolene Oliver, Aaron Tuck and Emily Tuck

i) Seeking Information on Missing Family Members

The members of the Tuck Oliver family had a **horrendous** experience seeking information about their family members living on Cobequid Court in Portapique. They deserve to have that emphasised here as the inquiry proceedings draw to a close and the Commissioners prepare to write their report.

The following information is outlined in the Foundational Document, Information Seeking from Families and NOK Notifications, (P-002222, COMM0058972 beginning at page 41). Their ordeal began at approximately 7 am MST, 10 am Atlantic, when Bonnie Oliver placed a routine Sunday morning call to her daughter Jolene's cell phone. There was no answer. When a second call shortly after that was not answered Mrs. Oliver assumed the family had gone out and Jolene was not able to take the call.

Then she turned on her television. She saw news reports of shootings occurring in the community of Portapique, NS. Mrs. Oliver, along with her daughters Crystal and Tammy, immediately made multiple attempts to reach Jolene, Aaron and Emily by phone and texts with no results.

Bonnie Oliver then called the RCMP, was told they were busy and try calling the RCMP detachment in Bible Hill but when she did, she received no information but left her own contact information and provided information about the family members she could not make contact with. By 11:00 am Atlantic time Bonnie Oliver was so distraught that Crystal and Tammy took over the efforts to reach the RCMP.

In the early afternoon Emily's cousin Sara Mendiuk, began reaching out to Emily's friends via social media to see if anyone had news but no one had information on the family.

Throughout the afternoon the family members continued their efforts to reach RCMP by calling 911, and later by calling one of the RCMP media officers who they had seen give an update on the news. That call was answered, and they gave their contact information and provided personal identifying information for Aaron, Jolene, and Emily.

At approximately 3:20 pm Cpl. Jarrett MacDonald took over from Sgt. Andy O'Brien as scene security commander in Portapique. His notes reveal that over the course of his shift the OCC sent messages to the MWS in his car about inquiries from people worried about people they knew who lived in the area. At least one of these, were from a woman in Alberta looking for information about her sister who lived on Cobequid Court.

Finally, at approximately 4:49 pm Cpl. MacDonald attended at the Oliver Tuck and the Bond residences on Cobequid Court in response to these inquiries and he discovered two deceased at each residence. It was not until additional members were tasked to go back with him, approximately 5:30 pm or thereabouts, to canvas all homes in the area that the body of Emily Tuck was also discovered.

Between 4:02 pm, and 6:30 pm, an individual at the OCC sent several emails to the Major Case Command Triangle relaying requests for information about Jolene, Aaron, and Emily Tuck, including requests from Bonnie Oliver, Jolene's employer, the mother of a friend of Emily's, a friend of Aaron's and Crystal Mendiuk, Jolene's sister.

Then at 7:55 pm another email went to the Major Case Command Triangle advising of and inquiry from Sara Mendiuk to 911 seeking information about Jolene, Emily, and Aaron. This was sent to Cst. Bent at 8:12 pm.

We know from the sources used to compile the Foundational Document that the search of all buildings on the roads in the community were completed at 8:35 pm and no other deceased, aside from the discovery of the five new victims on Cobequid Court were found.

We have taken the time to set out this detail to demonstrate that on this issue, the delay in responding to these reasonable and expected inquiries about people living in the heart of the area where the mass casualty began, fell **woefully short**!

It demonstrates that there were no pre-established protocols or procedures existing to respond to this aspect of a mass casualty situation, of any type, that being the influx of calls from those concerned for loved ones who may have been in harms way and who they have not been able to contact. In today's world of rapid-fire news dissemination via social media and all the related tools people use to share information electronically, it has to be expected to happen. Law enforcement agencies, wherever they are, need to be prepared to deal with the influx of calls about possible victims in a planned and organized manner and with people dedicated to that task.

This issue of inquiries from the families or friends of persons unaccounted for seeking information on loved ones who are not responding to those trying to contact them falls under several of your

mandates to inquire into and make recommendations including 1) the responses of police, specifically here the RCMP, 2) the steps taken to inform, support and engage victims, families and affected citizens.

To that end, we refer to the Participant Consultation session on Victim Advocacy Organizations held on August 29, 2022 and in particular the presentations on behalf of the Toronto Police Service and the Peel Regional Police on their respective units now in place to respond to a variety of areas of a mass casualty event but in particular to do the intake and follow up on incoming inquiries about missing persons, persons not accounted for and which friends and relatives have reason to believe may be in the midst of whatever event is occurring. Their model includes having people dedicated to that task.

We believe the TPS unit is called the Victim Management Response and the Peel Regional unit, the Major Event Management, Mass Casualty Unit. The presentation of these initiatives indicated that both are works in progress, but they have established the framework for the response including who does what, when and how.

The information shared by these presenters, Insp Thomas Warfield, and D/C Helen Burton for Peel Regional Police and Cst. Danille Bottineau for Toronto Police Service was instructive of how taking the initiative to be proactive and prepared for worst case situations can and should be on the radar for all policing agencies in this country not the least of which is the RCMP in its role as both a national police force and service provider of contract and indigenous policing across the country.

Of key interest in both presentations was the existence of personnel, in some cases civilians, dedicated to taking calls from people seeking information on possible victims, and standing up very early on a 1-800 inquiry line for people to call into and provide the information on those they are looking for and then using their procedures and the technology they have ready, to take the information received and put it into their system and things flow from there. They have people trained to use software that then tracks the information coming in and matches up information on inquiries with information coming in on victims.

This takes the load of the shoulders of those dealing with the immediate response and establishes an organized, methodical process for addressing these inquiries which are a natural and expected part of such events. It does not appear from the presentations on these two examples of mass casualty event management units that it is necessary to have full time dedicated staff and that makes sense. Logically this could be units that stand up when needed and those trained and tasked to carry out the functions assigned to the unit move into action as needed.

Imagine how much easier things might have been for Bonnie Oliver and her family members if there had been a 1-800 number to call to make inquires about their family and to have that information actioned and responded to in a timely manner.

RECOMMENDATION #4

In consideration of the ordeal of our clients, we urge this Commission to make a recommendation to address these concerns. Specifically, we ask for a recommendation ***that the RCMP be directed to implement a "mass casualty management unit" in each of its Divisions across the country modeled on those in place with the Toronto Police Service and the Peel Regional Police and to begin that process not later than six months from the date of the recommendation.***

RECOMMENDATION #5

We also invite the Commissioners to consider broadening that recommendation to include that it is recommended that ***all police service provider agencies across the country take steps to implement a mass casualty management unit with the option for small and medium sized police services to enter into arrangements with larger police departments in their area or the RCMP provincial division in their locale to provide that specialized service when needed.***

ii) Next of Kin Notification

This is another area that was dealt with in an inadequate manner as it related to the Oliver Tuck family and for other families as well, including our client, the family of Lillian Campbell.

The Foundational Document, Information Seeking from Families and NOK Notifications notes, at pages 45 and 46, that there are conflicting versions of how, by whom and when the Oliver Tuck family members were informed by RCMP of confirmation of the death of Aaron Tuck, Jolene Oliver, and Emily Tuck.

Several family members had called leaving names and phone numbers including Jolene Oliver's sister, Crystal Mendiuk and her teenage daughter, Sara. Despite having Crystal Mendiuk's own cell phone number and that of Jolene's mother, Bonnie Oliver, Ms. Mendiuk recalls that it was her teenage daughter who was phoned at approximately 8:38 pm to be informed of an update from her family members' home. It was and remains upsetting to think that more care was not taken to ensure it was at least an adult family member being contacted.

While in many respects it was not upsetting that the actual call, several hours later, to confirm that there were two adults and a younger female deceased in the home, went to Jolene's sister Crystal, in reality the next of kin in that situation were Jolene's parents, Bonnie and John Oliver.

These notification efforts occurred following long hours of trying to have police look into the fact their family members in Portapique could not be reached and were unaccounted for.

Throughout the day the family, far away in Alberta, were following news updates, including changes to the number of victims which at one point increased by three, the same number of unaccounted for members of our client's family.

The details of the discrepancies between RCMP members account of when and to whom calls were made between approximately 8:38 pm and 11:30 pm AST are set out in paras 165 and 170 of the FD on NOK Notifications. It is unlikely to be resolved at this point.

The key point is that between the time deceased were first found at in the Oliver Tuck family home at 4:49 pm, and when confirmation was given to the family at either10:15 pm or 11:30 pm AST, distraught family members thousands of miles way were in agony wanting to know if their loved ones had been killed.

Considering they had been calling for many hours and had given many different call takers detailed information on where their family lived, that they could not be reached, identifying information for each of the three, it still took 5 to 6 torturous hours to be given notification after the discovery of that crime scene. That was too long.

Especially considering that that crime scene that had already taken approximately nineteen long hours to even discover. That in and of itself being a significant shortfall in the RCMP response to and management of the MC event.

Yes, it was a horrific event, on a huge scale, and police were coping with an unimaginable situation. But the victims, and their families, deserved to have better and quicker attention to identifying victims and notifying next of kin.

RECOMMENDATION #6

We suggest that a recommendation be made ***that the RCMP review and improve existing next of kin notification protocols and specifically develop alternative protocols applicable to mass casualty events where "normal" next of kin protocols would unduly delay the notification of family members of a mass casualty event***.

iii) Family Liaison Officer and Victim Services

Our clients are highly positive in their comments on the support and attention they received from the appointed family liaison officer, Cst. Wayne (Skipper) Bent. Beginning in the very early days after and continuing throughout, they were appreciative of his efforts to assist them and his diligence in trying to keep them fully informed.

However, the evidence that came out during the inquiry proceedings supports that this was a mammoth task to assign to one person and it is apparent that many families feel short changed as a result. In fairness to the many families involved in this event, and to Cst. Bent, more liaison officers should have been appointed for this event.

Further, as the evidence has also shown, members like Cst. Bent, tasked to take on that role have not had the benefit of any formal training to carry out that very important role.

On that point we refer again to the mass casualty units created by Toronto and Peel police services. We understand from those presentations that family liaison persons, or similar roles, are assigned to those units and that they have in place training programs for that as part of their Mass Casualty Unit. The RCMP should look into what is being done there and see if they can develop a family liaison training program without having to totally re-invent the wheel.

RECOMMENDATION #7

We suggest there be a recommendation ***that the RCMP immediately identity existing members within each Division to be designated and trained as family liaison officers to be deployed when required on a case-by-case basis.***

iv) Victim Services

Our clients availed themselves of a number of services through the Nova Scotia Victim Services program. However, their location in Alberta was a significant factor and caused a number of issues for them which would not have been the case for those seeking the services here in Nova Scotia.

Contact with the family by the agency here in NS was reasonably prompt, at 4 days post event but it would have been of assistance to have had a call in a shorter time period.

It was difficult to get a clear picture of what was available, how services could be accessed, paperwork and the process to obtain counselling was difficult and stressful on the family.

When services were being accessed the distance factor was still an issue. For example, to obtain sufficient funding to cover counselling for family members in Alberta as the funding provided by Victim Services in Nova Scotia was not sufficient to meet the higher fees for those services in

Alberta. Although it worked in the end, with additional amounts being provided, it took a lot of back and forth and the effort to navigate all those issues added to the stress and negative impact of the tragedy that the family were already experiencing.

The people at Victim Services were helpful on one level but overall, it was very difficult to utilize and coordinate from afar. Much of the sourcing of appropriate counsellors for this kind of trauma situation fell on the family members themselves as the people they were dealing with in Nova Scotia did not have the information or knowledge of what was available in their particular locations in Alberta, nor the names etc. to refer them to.

Had there been a procedure to transfer them to the similar program/agency in their own province it likely would have taken a great deal of stress and anxiety off of the family members who were trying to get access to services.

It is not clear that there exists an ability to transfer victim services cases to other jurisdictions, with billing back to province of origin. In the absence of existing arrangements, it would be an improvement, and a practical recommendation, for that to be looked into and implemented if possible.

RECOMMENDATION #8

Therefore, we request a recommendation to the provincial government of Nova Scotia ***that it explore with other provinces exchange of service arrangements to allow for transfer of cases where eligible recipients of the victim services program in any province who reside in another province have their case file transferred to their province of residence who will work with them to arrange and coordinate the appropriate services for the situation with bill back arrangements to the province where their eligibility for services arose.***

3. Key Issues of General Application

Under this heading we will address a wide range of topics, some briefly, some in more depth. Some topics will have recommendations connected to them, some will simply be our thoughts and opinions to be taken into consideration as the Commissioners formula their conclusions and recommendations. We have grouped the issues being dealt with in this section into broadly worded topic areas which in most cases will then be broken down into specific areas of issues or concerns. The broad topic areas are: i) police response to the mass casualty; ii) community safety and wellbeing; iii) structure and approach to policing; iv) access to firearms; v) Mass Casualty Commission Process

i) Police Response to the Mass Casualty

We begin this section by expressing our gratitude to all the RCMP members who responded on the ground in Portapique the night of April 18 and at all the subsequent locations throughout the day on April 19. The first on scene in Portapique are to be commended for immediately forming a three person IARD team to enter the community, with the fourth member securing the intersection of Portapique Beach Road and Highway 2. At that point they had no clear understanding of what they were dealing with nor the carnage they would encounter that night and the following day.

Many other members, from general duty on up the ranks, those manning the OCC, the Critical Incident Commanders, specialized units like the ERT team, dog services and others arrived throughout the night and into the next day. We are certain they all showed up intent on doing everything in their power to serve and protect members of the public from the harm. We want to express our gratitude and thank all of them for their service.

We want to also express thanks and gratitude to other first responders, to EHS members, to local volunteer fire brigades and EMO for their roles during and after the MC event.

As we address this topic our objective is not to review in detail the entirety of the record of who did what, when and where during the police operational response from the time the first 911 call came in until the discovery of the last to be know crime scenes on Cobequid Court late Sunday afternoon. We will make only a few specific references to key information that is part of the record from Foundational Documents or testimony at the inquiry primarily for the purpose of context for general comments and our recommendations.

The first 911 call on April 18, from Jamie Blair, came in at 10:01 pm. She said her husband was shot, and on the deck, and mentioned the name Gabriel and that an RCMP car was in the yard. The call was dispatched by the OCC to Colchester RCMP members at 10:04:03 pm. All four general duty members on duty that night, Csts. Stuart Beselt, Adam Merchant, Aaron Patton, and Vicki Colford left wherever they had been and headed to Portapique. Cst., Beselt arrived at 10:25:57, Cst. Merchant at 10:28:53, Cst. Patton at 10:28:57 and Cst. Colford at 10:32:16.[15]

A second 911 call came in at approximately 10:19 pm which we know was from the children who advised, among other things, that “it was a police car”.[16]

Just after arriving Cst. Beselt encountered Andrew and Kate MacDonald. Andrew MacDonald had been wounded by the perpetrator. Cst. Merchant arrived and he and Cst. Beselt headed down

[15] P-000005 (COMM0050894) First Responders Actions in Portapique, paras. 1-4
[16] Ibid, para 3

Portapique Beach Road on foot as an IARD team. Cst. Colford had not yet arrived and so Cst. Patton remained briefly with the MacDonald's and spoke to them. He broadcast information he obtained from them including that the shooter was named Gabe and he has a car that looks like a police car and his approximate age.[17]

When Cst. Colford arrived Cst. Patton headed down Portapique Beach Road to join up with Csts. Beselt and Merchant.[18]

In speaking with the MacDonalds at the head of Portapique Beach Road Cst. Colford was told of another possible exit out of the community by Kate MacDonald and Cst. Colford made the following broadcast over Colchester Radio:

> "10:48:41 PM – Cst. COLFORD (H-05B08/H-BH P12): Mill Brook [*sic*], if you guys want to have a look at a map, we're being told there's a road, kind of a road that someone could come out, before here. Ah, if they know the roads well.[19]

As set out in the Portapique: April 18-19, 2020, Foundational Document, it is believed that the most plausible timeline for the perpetrator exiting Portapique the night of April 18 is between 10:41 pm and 10:45 pm.[20]

In addition to the initial containment point on Portapique Beach Road, established on the arrival of the first member, Cst. Beselt at 10:25:57 pm, (subsequently manned by Cst. Colford together with Cpl. Jamieson) five additional containment points were established at Five Houses Road and Highway 2 (10:51 pm); Bay Shore Road and Highway 2 (11:04 pm) both to the west of Portapique Beach Road and three locations to the east of Portapique Beach Road, the closest, at the eastern end of Brown Loop and Highway 2 was first manned at 5:02: am April 19. Two locations further away to the east of Portapique were manned at 12:01 am, April 19.[21]

We do not intend to summarize the entirety of the police response, those details are thoroughly set out in the various Foundational Documents including those dealing with the different locations of crime scenes, command post operations, the Operational Communications Centre, command decisions, RCMP Public Communications, confirmation of the replica RCMP cruiser and the Emergency Response Team (ERT) among others.

[17] Ibid, para 59
[18] Ibid, para 60
[19] Ibid, para 78
[20] P-000006 (COMM0050895) Containment Points in and Around Portapique, para 1
[21] Ibid, paras 8,14,19,23,26 & 27

Those various documents and the testimony of the general duty members, critical incident commanders, other command level members, the Risk Managers and others has provided a vast amount of information, too vast to adequately summarize.

We have read the Foundational Documents, read the interview transcripts, and listened to the testimony of those called as witnesses. We feel comfortable in making a few observations which in our view are not surprising and have been raised and discussed at many different points during the inquiry proceedings.

These observations include things like:

- some information taken by 911 call takers not being passed on;
- the command and control confusion created by multiple command level members early on giving directions to the members on the ground in Portapique, both before and after the Critical Incident Commander was on scene and supposedly had taken control;
- the fact some critical pieces of information, like the existence of a wounded witness and of another exit point from the community, did not get up the line to those in command;
- the early tweets from the RCMP not adequately portraying the seriousness of the situation;
- the apparent reluctance to accept the information from the first 911 calls and the witness Andrew MacDonald that the perpetrator was in a car that looked like a real police car;
- that the key witness information on the car was not known to the Critical Incident Commander;
- that lack of GPS tracking of members out of their vehicles was a major concern and a key reason for not sending in additional IARD teams;
- the lack of accurate and easily accessible mapping technology that night;
- the confusion from heavy traffic on the radios such that many transmissions got missed;
- that many members were not fully aware of all the features of their radios and how to use them properly, such as the Request to Talk button;
- the inexcusable and unnecessary lengthy delay on Sunday morning in releasing the information on the perpetrator's use of a replica police car to the public after verification of the car was obtained early that morning but also, failing to accept the information about the car when it was known from the first 911 call and also from subsequent witnesses, being the Blair children and Andrew and Kate MacDonald, all within the first 30 minutes of the start of the event;
- shortfalls in containment, security and control and discovery of crime scenes, in particular the failure to discover the crime scenes on Cobequid Court until almost 19 hours after the fact despite information coming in earlier in the day on April 19 of people unaccounted for on that street.

This recap highlights some of the shortfalls that occurred during the response to the mass casualty. In discussing these as shortfalls, we do not want to take away from the tremendous efforts of all

those involved in responding to this horrific event. However, this inquiry is tasked with looking into not only what happened but what lessons can be learned and from those, look for ways to be even better prepared and equipped to respond to similar events in the future if necessary.

We accept that in some instances, some of the shortfalls were likely unavoidable for this event and not anyone's fault per se. Nonetheless, it is possible for those to be acknowledged as something to be better prepared for going forward.

Aside from containment at Portapique Beach Road itself, accomplished by the arrival of the first responding member, the next containment point was only set up approximately 25 minutes later, at Five Houses Road and Highway 2 when a member from Cumberland detachment arrived there. However, first containment point to the east of Portapique Beach Road was not in place until midnight and additional members had arrived from points east well before that. For example, Cst. Chris Grund announced his arrival at Portapique Beach Road at 10:59:10 pm.[22]

It is well established that Cst. Vicki Colford's broadcast at 10:48 pm of another possible exit out of the community, information she was given by Kate MacDonald, was not picked up by anyone at the time. This is a prime example of the failures and breakdowns in the dissemination of firsthand witness accounts of critical information which also happened with information on the name and description of the perpetrator, including the police type clothing he was wearing, and of course, the key information that the vehicle he was in looked just like a police car.

We acknowledge that considering the timeline of when the perpetrator is believed to have left via the blueberry field road, it is unlikely that even immediately locating that exit point and containing it would have meant catching the perpetrator. He was almost certainly gone by then. However, what it would have done, that could have made a difference in the police response overnight and into the next day, is allowed those directing the response to have more fulsomely considered the idea that their subject of concern was no longer in the community and that he could be anywhere at that point.

A missed opportunity to obtain key information from a witness at the scene occurred when David Faulkner, in the car leaving Portapique Beach Road behind the MacDonalds, was waved on once it was determined he was not the subject of concern, without taking a few moments to ask him if he had seen or heard anything that might be of use to the police. He had in fact, seen the replica marked police car several times and knew it had turned down Portapique Beach Road from Orchard Beach Drive as he drove out behind it and Andrew MacDonald. That would have been helpful information to have gathered at that early point in the police response.

[22] Supra, note 15, at para 80

Arising from the topics covered here we have three specific recommendations to propose to the Commissioners. They do not address all the points made under this topic. Many of the areas of concern addressed here however are ones that we hope the RCMP have noted during the course of the inquiry as being areas where thought should be given to ways to improve such as the dissemination of critical information during the course of the event to those who should get it in a timely manner. We have struggled with how to frame a recommendation to adequately address that point.

Recommendation #9

We request a recommendation to the RCMP ***that in addition to the OCC, all detachments have access on site to Pictometry, or a comparable mapping program, and that it be mandated that all detachment commanders as well as all general duty members be trained in the use and application of that technology and that this recommendation be implemented within six months.***

Recommendation #10

During the course of the inquiry the issue of the inability to track members by GPS if they had to leave their vehicle arose often in discussions and testimony. We referred to this in our observations above. We also heard during the testimony of Commissioner Lucki, that the technology to do that is now being put in place, via the ATAK platform, beginning with ERT teams across the country and will be available for all general duty members by the end of 2023. We think this is such a critical issue on a number of levels, from officer safety to operational benefits in the field. Therefore, despite the assurance from the Commissioner of the commitment to that initiative, it is worthy of a recommendation from this inquiry as further assurance that the initiative is followed through on and so we request a recommendation to the RCMP ***that the current initiative to equip and train all general duty members on the ATAK program for GPS tracking when outside of their vehicles be implemented as per the current target date of on or before the end of 2023 for all general duty members.***

Recommendation #11

Further to our comment above that some of the areas we identified as having been a shortfall in the immediate response are nonetheless difficult to address via specific recommendations we suggest the following recommendation to the RCMP and to other police training facilities, which falls within the Commissions mandate to comment on police policies, procedures and training in respect of active shooter incidents, and that is ***that the mass casualty event of April 18 and 19, 2020 be made a case study at the RCMP Depot and at all other police training colleges and academies to aid in training programs focused on active shooter incidents.***

ii) Community Safety and Well Being

There are many issues and areas of concern arising from the MC that are related to the topic of overall community safety and well-being. We will comment here on a few select areas.

The areas of firearms complaints, threat complaints and third-party reporting of domestic violence incidents are key areas which this inquiry heard about and which at their core impact the safety and well being of communities across this province and in fact the country.

We believe the evidence before the inquiry supports that local RCMP carried out inadequate investigations years earlier, in 2010, 2011 and 2013, of prior complaints and information connecting the perpetrator to firearms, threats against relatives and incidents of domestic violence which will always leave questions of whether different actions then could have prevented what happened in 2020.

One example is the information from Brenda Forbes about the complaint she called into the RCMP about the perpetrator's possession of firearms and assault of Lisa Banfield in 2013. Her evidence during her appearance as a witness was compelling. The testimony of one of the responding officers, Cst. Troy Maxwell, that it was about neither firearms or domestic assault but instead was a complaint about driving fast or dangerously around the community was not so compelling, especially given the presence of names in his notebook that connect to the information Ms. Forbes related about the domestic assault. The two accounts can not be reconciled. If Ms. Forbes' account is the accurate one, it demonstrates a serious failure to properly investigate a domestic assault allegation and allegations of possible illegal firearm possession.

It is extremely concerning for the community at large to think that complaints about possible illegal firearms possession and other possible offences that involve violence or threat of violence may not be receiving the attention they deserve. Granted, there are threshold requirements to be met before police following up on such complaints can take invasive measures like obtaining a search warrant to fully investigate such allegations.

We acknowledge that initially the police may not have had enough to obtain a warrant to search the perpetrator's properties for weapons. However, in our view it is apparent that other investigative steps, such as speaking to other neighbours to see what additional information could be obtained and which might have led to establishing grounds for a search warrant fell short.

In the case of this perpetrator, the evidence supports that many people knew of his illegal firearms possession and of his past time of firing off guns into the riverbanks behind his cottage. Yet even if more of those people had called in tips or complaints to police, would that have been enough for a search warrant to be granted?

It is impossible to say, but the necessary threshold for a warrant in such situations will never have a chance of being met if the investigative response to the information provided to police in the first place is not thorough and as complete as it can be. Therein lies what we suggest is the crux of what happened in this case. The question is how to address that going forward to help ensure safer communities for us all.

Recommendation #12

We request the Commissioners consider making a recommendation ***that the RCMP, on a national level, develop and implement a standardized protocol for investigative steps that must be undertaken in response to third party information/complaints of persons believed to be in illegal possession of firearms which protocol would require having a senior officer to the investigating member review and sign off on the record of investigative steps taken in regards to the complaint.***

The issue of lack of local knowledge of communities in their service area of general duty members, in particular in rural areas and whether enough is done to seek out sources for that knowledge in an emergent situation came up during the inquiry and is a concern under this general topic of community safety and well being.

There are many examples on April18 and April 19 of where members did not have local knowledge which unfortunately had a negative impact on the outcomes. From the first responding members to the Risk Manager, to the Critical Incident Commanders, and to the ERT Team. Many were from outside Colchester County and few had a working knowledge of the roads in the area. When it was clear that additional resources were needed, instead of calling Truro Police Service for assistance, the RCMP called in members from other detachments in Nova Scotia resulting in longer response times, and even more members who were unfamiliar with the area. This resulted in two members becoming lost in the Town of Truro and requesting directions from Truro Police officers; and one of the members from outside Colchester County being assigned security at the Onslow Belmont Fire Brigade. This member did not know where the shooting was taking place and indicated he was pretty confused on where the event was going on. The perpetrator drove by his location at the firehall.
The command post and comfort centre were set up at local firehalls. There were Fire Chiefs and Deputy Fire Chiefs as well as community residents there. These people had local knowledge of the roads, back roads, the people, and the area. They were not called upon.

Nova Scotia Conservation Officers, Mike MacDonald and Dale Cashin could have been called upon. These Conservation Officers in Colchester County knew the geography of the County, the

communities, roads, and back roads. They had mapping tools, knew the people, and were available 24/7.

Recommendation #13

We request the Commissioners consider a recommendation that ***the RCMP be strongly encouraged to seek out, in a timely manner, appropriate assistance from all available community resources including Conservation Officers, local fire services, neighbouring municipal police services, and others when responding to a critical incident.***

The RCMP continues its long-held tradition of routinely transferring members from posting to posting every so many years. The evidence on that issue, from Commissioner Lucki if we recall correctly was that there is no set time period, but transfers would likely occur after 3 to 6 years in one post. It was explained that in more recent times this practice is sometimes modified on a case-by-case basis related to the personal family situation of members. In some cases, transfers are not done due to the personal situation of the member and sometimes they are always going to happen in the case of northern and other isolated locations. It was acknowledged by the Commissioner that there are pros and cons to the transfer practice.

In our opinion, one of the cons is that members are not in an area, especially rural detachment postings, to become very familiar with the communities they are in, including its geography before being moved on to another unfamiliar area. We can accept that for some members, the mobility opportunities that the RCMP organization affords them may be part of the appeal as opposed to joining a municipal police force that has a defined single location. However, we suggest that there can and should be a greater effort made to move towards longer term postings and shorter-term posts should become the exception and not the norm.

Recommendation #14

We request the Commissioners consider a recommendation to the RCMP ***that it review its current practices on regular transfers of members and to develop greater options and opportunities for all members to have long term postings subject always to individual preferences for mobility including moving for career advancement reasons.***

Finally, under this heading, we want to comment on the issue of creation of a threat assessment coordinator. The creation of such a position was a recommendation that came out of the Mayerthorpe Inquiry conducted by Albert Assistant Chief Judge Daniel Pahl. ACJ Pahl explained the position this way:

> "Each detachment should designate a member (as distinct from staff) to fill the role of Threat Assessment Coordinator (TAC). This person would be primarily but not exclusively responsible for the collection and maintenance of master and individual threat assessment files. … Threat assessment would remain the collective responsibility of the detachment. All members would be charged with the responsibility to provide ongoing intelligence to the TAC, both formal and informal."[23]

The inadequate investigations years earlier in 2010, 2011 and 2013 of complaints and information connecting the perpetrator to firearms, threats against relatives and incidents of violence as well as domestic violence will always leave questions of how the perpetrator "fell through the cracks" of our justice system. Perhaps a threat assessment coordinator would have made a difference.

Recommendation #15

We request the Commissioners to recommend to the RCMP ***that the recommendation from the Mayerthorpe inquiry for the creation of a Threat Assessment Coordinator be implemented on a national basis as proposed in the Mayerthorpe Inquiry Report.***

iii) Structure and Approach to Policing

This inquiry has accumulated a plethora of information and reports on policing. Policing generally and, in particular, the RCMP both in its role as a national police force and as a provider of contract and indigenous policing in most provinces.

The information was gathered in multiple ways, including: previously existing reports, reviews, articles on policing and/or the RCMP; expert reports commissioned by the MCC on various aspects of policing in general and specifically related to the RCMP; information gathered from participants in a number of roundtable discussions as well as supporting documents from those sessions; and, from the in person testimony of witnesses from the RCMP, including command level officers up to Commissioner Lucki and witnesses from other police services including Chief David MacNeil of Truro Police Service (TPS) and Chief Daniel Kinsella of Halifax Regional Police Service (HRP).

We do not intend to review and/or comment on all aspects of the RCMP as a policing agency which has been examined during the inquiry. That would be a report in and of itself because there is a lot that could be commented upon most of which is already documented in the many previously existing reports, reviews, and articles on the RCMP organization tendered before the inquiry.

[23] P-004183 (COMM0058319) Mayerthorpe Public Fatal Inquiry Report at pg. 22

We will not list them all there but two that we found of particular interest and relevance for possible changes to policing in Nova Scotia are the report of the British Columbia Special Committee on Reforming the Police Act (of BC), *Transforming Policing and Community Safety in British Columbia,*[24] and the expert report commissioned by the MCC, *Community-Engaged Rural Policing: The Case for Reform and Innovation in Rural RCMP Policing*[25] authored by Chris Murphy and Cal Corley.

We think it is not only a fair statement but really an understatement to say that there is much about the RCMP that desperately needs to change, both on an organizational level and on an operational policing level. Despite the many past reports and the recommendations flowing from them, Murphy, and Corley, in their report, *Community-Engaged Rural Policing* conclude little progress has really been made to deal with the issues identified over the past 30 years or so.

The various materials before the MCC on the RCMP have noted many common and continuing concerns with the organization as a whole ranging from a toxic culture ingrained within the organization to issues arising from the deeply rooted para-military origins of the RCMP police force including command and control structure, the approach to cadet training at depot, management structures that support the status quo and contribute to the perpetuation of an outdated organizational military based format and inhibits real change to create a national police force based on a modernized policing model that would better serve the public in this country and the members of the RCMP itself.

We were continually astounded by the number of times officers from H-Division HQ, and on up to the Commissioner herself, responded to questions by announcing that they didn't know who was responsible for a task, decision etc. other than, it was not their area! The evidence continually depicts an organization so big, so hierarchical, with such a large and confusing management structure that no one seems to take responsibility for decisions. There is no accountability. To her credit Commissioner Lucki, <u>when pressed</u>, conceded that ultimately the buck stops with her as Commissioner.

Across Canada there is growing dissatisfaction with RCMP contract policing. In British Columbia, the Routley Report[26] recommended British Columbia stop using the RCMP and create its own police force. The committee unanimously agreed a provincial force would create more consistent standards for police response, training, and oversight across British Columbia.
That drastic and complete overhaul of the approach to policing in that province was proposed in the hope of gaining greater accountability, transparency and improving public trust in policing.

[24] P-004596, Transforming Policing and Community Safety in British Columbia, April 2022 COMM0058952, (the Routley Report)
[25] P-004635, Community-Engaged Rural Policing: The Case for Reform and Innovation in Rural RCMP Policing COMM0063515
[26] Supra, note 24

The report indicates that concerns with the current policing systems, primarily being the RCMP, included things like systemic racism, need for greater accountability, concern about responses to mental health and addiction calls, general lack of trust in current policing, inadequate RCMP oversight, and lack of resources.

Colchester and Cumberland Counties in NS have in the past called for reviews of RCMP contract policing services. Colchester County has expressed concerns with RCMP staffing levels and costs since 2015 leading it to request the Truro Police Service to provide a formalized proposal for policing of Colchester County. That was put on hold in 2020 following the mass casualty but it does not appear it was because it was not considered a real option to the RCMP.[27]

While recommendations to accomplish a complete overhaul of the RCMP as an organization may be beyond the scope of this inquiry, there are some areas at least that we think can be addressed in your recommendations. Two areas of concern we will speak to, out of the many raised during the proceedings, are broad based, national concerns as we see them. They are first, the RCMP's current, historical approach to training, being the 6-month depot program and second, the chronic understaffing of detachments across this county with general duty members.

We seriously question the RCMP's traditional 6-month basic training model at "Depot" followed by the six months on the job first posting as the "best model" going forward. In his report, Broken Dreams Broken Lives, the Honourable Michel Bastarache leveled significant criticism of the para-military training approach which continues at Depot and its contribution to the toxic culture in the RCMP. In his view it is time to revisit cadet training and ask whether the RCMP's traditional approach is the right one in a "modern policing context".[28]

Murphy and Corley, in their report discuss factors impacting detachment policing in small towns and rural communities generally and one topic was recruit training and the following is set out in the report:

> Leuprecht (2020), Bastarache (2020), Maher (2020) and others have observed that many aspects of RCMP training and induction at the RCMP academy in Regina are no longer commensurate with the requirements of a modern civilian-oriented and community-based policing service. Rather, too many aspects of the training at Depot reinforce an outdated traditional paramilitary culture. This reinforces the internal organizational culture of the RCMP and exacerbates its separation from the community.[29]

[27] P-001032, Transcript of MCC interview with Chief Dave MacNeil of TPS, COMM0003767, page 123
[28] P-003648, Broken Dreams Broken Lives, The Honourable Michel Bastarache, COMM0058301, pg 8
[29] Supra note 25 at pg. 35

Recommendation #16

We request the Commissioners include a recommendation ***to the Federal Government and the RCMP that steps be initiated immediately to development a minimum two year post-secondary police education and training program to be the primary training program for individuals pursuing a career in policing in Canada and that consideration be given to tasking one or more of the existing police training facilities in the country to develop and deliver the program in one or more locations across the country and further, that in the meantime, it be recommended to the RCMP that it begin immediately to review the format of its cadet training program at its Depot to address concerns identified in this inquiry and other reviews and reports.***

iv) Access to Firearms

We have chosen not to comment in any significant way on the topic of access to firearms generally or the perpetrator's access specifically. We note, as has been documented in the evidence and information before the inquiry, the perpetrator acquired and possessed the firearms found in his possession, whether he used them in the mass casualty or not, illegally. He smuggled various of the firearms over the US Canada border without detection. All the existing laws, and there are at present significant legislative provisions, in statue and regulations, governing the access to and possession of firearms, did not prevent him from finding a way to obtain firearms by smuggling them in from the US across a land border crossing.

We chose not to suggest additional legislative provisions on the possession of firearms. We suggest the area of greatest concern in this case is the fact that apparently, on three different occasions, the perpetrator was able to successfully smuggle a firearm across the border between Maine and New Brunswick. It is now known that on at least one occasion he concealed the weapon in the rolled-up tonneau cover of his half ton truck. Hopefully we can assume Canadian Border Services Agency (CBSA) agents are now requiring all tonneau covers to be rolled back and inspected before entry into Canada!

Recommendation #17

We request consideration of the following recommendation arising from how the perpetrator acquired at least 3 of his firearms: ***that the CBSA be directed to review its current practices and procedures related to investigating, detection methods, criteria to inspect and search for the smuggling of firearms and within six months of this recommendation provide an update of its current practices and areas identified as needing improvements and what additional methods have or are being contemplated to increase detection of the illegal importation of firearms into Canada.***

v) Mass Casualty Commission Process

Our final comments relate to concerns of our clients, and we as their counsel, to some issues around process that arose during the course of the inquiry. Some of these concerns were raised orally at various stages of the proceedings as they arose. However, we believe it important to note them here in our final submission on behalf of our clients.

It should be no surprise to know that the biggest concern relates to the limitations placed on participant counsel's questioning of certain witnesses because of accommodations granted to them by the Commissioners, usually on the recommendation of Commission Counsel. The most troubling situations were those where participant counsel were denied the opportunity to question a witness directly. While counsel were generally, if not always, given the option of sending in questions to Commission Counsel to ask, and we took advantage of that in those cases, neither our clients nor we were satisfied that that process was a true replacement for asking questions directly.

We often approached questions being posed by participant counsel in a cooperative way with other counsel in that we would consult with others on what they planned to ask, what our questions might be and often had our questions incorporated into another counsel's line of questioning. But it was our choice whether we asked questions directly or had other participant counsel include our questions with theirs. It was when all participant counsel were prevented from asking questions directly that we believe the process suffered from a degree of unfairness.

These situations were allowed on the basis that the particular witness required accommodation of some sort for a reason deemed by those assessing the request as being reasonable and necessary. However, rarely if ever did participant counsel have any real understanding of the basis for the accommodation. As counsel we found this approach disturbing for a variety of reasons but even more important to us, and we think for the MCC, our clients, the participants were impacted each time they learned of another witness, invariably a more senior RCMP member, being afforded an accommodation. One of our clients pointed out that they never have the benefit of any accommodation in their lives for the pain and hurt they carry with them all the time as they try to get on with their lives, go to jobs, do daily activities, all in the shadow of their experience of the mass casualty event. To them, the accommodations to those witnesses was unfair.

The other point on process relates to the overall timeline for the inquiry. In the beginning it was hard to appreciate the extent of the workload that would come as the inquiry progressed. Looking back now, in our view it is clear that the original timeline was definitely inadequate. It was not surprising to us that the Commissioners requested additional time to write the final report. We think additional time should have also been considered to have more time for proceedings, including to call more witnesses or recall, as needed witnesses who had already testified. As things progressed, some more information came to light on matters related to witnesses who had already

appeared. However, time did not allow for people to be recalled. Further, even several weeks after the close of proceedings, hundreds of documents have come in and been disclosed. That is hardly what one would expect to be happening after the close of proceedings. As counsel for participants, it is disconcerting to be writing and submitting final submissions while new disclosure continues to be received and exhibits tendered virtually.

In summary, we propose the following recommendations:

1. That the federal government task its Department of Public Safety and Emergency Preparedness and the Alert Ready service provider, Pelmorex, to immediately develop and implement a national public education campaign on the public warning system, Alert Ready.

2. That the RCMP, on a national level, review all strategic communications policies and procedures and revise them as necessary to mandate that all communications to the general public that are for the purpose of warning of immediate situations that pose a risk to public safety, but for which an Alert Ready warning is not being issued, be released to traditional media outlets, such as print media, radio and television as well as appropriate social media platforms and that this be undertaken immediately with implementation of new policies and procedures within six months.

3. That the federal government provide funding to the RCMP for the purpose of adding one additional helicopter, fully equipped for policing activities, to the Atlantic region air support and ideally that it be stationed in H-Division but if logistical reasons or staffing and maintenance issues make more reasonable to do so, then add it to the assets currently located at J-Division in Moncton, NB.

4. That the RCMP be directed to implement a "mass casualty management unit" in each of it's Divisions across the country modeled on those in place with the Toronto Police Service and the Peel Regional Police and to begin that process not later than six months from the date of the recommendation.

5. That all police service provider agencies across the country take steps to implement a mass casualty management unit with the option for small and medium sized police services to enter into arrangements with larger police departments in their area or the RCMP provincial division in their locale to provide that specialized service when needed.

6. That the RCMP review and improve existing next of kin notification protocols and specifically develop alternative protocols applicable to mass casualty events where

"normal" next of kin protocols would unduly delay the notification of family members of a mass casualty event.

7. That the RCMP immediately identity existing members within each Division to be designated and trained as family liaison officers to be deployed when required on a case-by-case basis.

8. That the Nova Scotia Provincial Government explore with other provinces the exchange of service arrangements to allow for transfer of cases where eligible recipients of the victim services program in any province who reside in another province have their case file transferred to their province of residence who will work with them to arrange and coordinate the appropriate services for the situation with bill back arrangements to the province where their eligibility for services arose.

9. That in addition to the OCC, all RCMP detachments have access on site to Pictometry, or a comparable mapping program, and that it be mandated that all detachment commanders as well as all general duty members be trained in the use and application of that technology and that this recommendation be implemented within six months.

10. That the current RCMP initiative to equip and train all general duty members on the ATAK program for GPS tracking when outside of their vehicles be implemented as per the current target date of on or before the end of 2023 for all general duty members.

11. That the mass casualty event of April 18 and 19, 2020 be made a case study at the RCMP Depot and at all other police training colleges and academies to aid in training programs focused on active shooter incidents.

12. That the RCMP, on a national level, develop and implement a standardized protocol for investigative steps that must be undertaken in response to third party information/complaints of persons believed to be in illegal possession of firearms which protocol would require a senior officer to the investigating member review and sign off on the record of investigative steps taken in regards to the complaint.

13. That the RCMP be strongly encouraged to seek out, in a timely manner, appropriate assistance from all available community resources including Conservation Officers, local fire services, neighbouring municipal police services, and others when responding to a critical incident.
14. That the RCMP review its current practices on regular transfers of members and to develop greater options and opportunities for all members to have long term postings subject always to individual preferences for mobility including moving for career advancement reasons.

15. That the recommendation from the Mayerthorpe inquiry for the creation of a Threat Assessment Coordinator be implemented on a national basis as proposed in the Mayerthorpe Inquiry Report.

16. That the Federal Government and the RCMP steps be initiated immediately to development a minimum two year post-secondary police education and training program to be the primary training program for individuals pursuing a career in policing in Canada and that consideration be given to tasking one or more of the existing police training facilities in the country to develop and deliver the program in one or more locations across the country and further, that in the meantime, it be recommended to the RCMP that it begin immediately to review the format of its cadet training program at its Depot to address concerns identified in this inquiry and other reviews and reports.

17. That the CBSA be directed to review its current practices and procedures related to investigating, detection methods, criteria to inspect and search for the smuggling of firearms and within six months of this recommendation provide an update of its current practices and areas identified as needing improvements and what additional methods have or are being contemplated to increase detection of the illegal importation of firearms into Canada.

We want to close by once again expressing to you, the Commissioners, ours and our client's hope that you are guided in writing your report and formulating your recommendations by the memory of the lives lost on April 18 and 19, 2020 and that the result of the work of everyone involved in this inquiry will be a fitting legacy for them.

Respectfully,

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