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October 5, 2022

File No. 7657-001

VIA E-MAIL - participation@masscasualtycommission.ca

The Hon. J. Michael MacDonald, Leanne J. Fitch and Dr. Kim Stanton, Commissioners
Mass Casualty Commission
1791 Barrington Street, Suite 310
Halifax, NS B3J 3K9

Dear Commissioners MacDonald, Fitch, and Stanton:

Re: Final Written Submissions

Please accept the following submissions on behalf of our client, Mrs. Beverly Beaton, mother-in-law of Mrs. Kristen Beaton and grandmother to Baby Beaton.

PART I – INTRODUCTION

1. April 18 and 19, 2020 is forever marked in Nova Scotia by the devastating loss of 23 innocent lives. The lives lost include Mrs. Kristen Beaton ("Kristen") and her unborn child who were murdered at approximately 10 a.m. on Sunday, April 19, 2020. Their deaths will forever impact Kristen's family, including her husband, son, brother, sister, father, and "other mother", our client, Mrs. Beverly Beaton.

2. The deaths of 22 people and Baby Beaton came at the hands of a monster. When such evil reigns, we turn to those trusted with public safety to protect us. However, a cascade of failures, errors, mistakes, and missteps by the Royal Canadian Mounted Police ("RCMP") prevented the RCMP from discharging its responsibility to maintain public safety.

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3. The Mass Casualty Commission (the "Commission") has dealt with difficult truths as it explored all facets of its mandate to inquire into what happened on April 18-19, 2020, and to make findings on the following:

    i. The causes, context, and circumstances giving rise to the April 2020 Mass Casualty;

    ii. The responses of law enforcement and government agencies to the Mass Casualty; and

    iii. The steps taken to inform, support, and engage those most affected by the Mass Casualty.

4. We now have a deeper understanding of the circumstances that unfolded during the 13 hours between 10:00 p.m. on April 18th and 11:30 a.m. on April 19th, 2020. We also understand the relevant dynamics and circumstances at play in the years preceding, which resulted in direct and indirect impacts leading to the Mass Casualty. We also have a more robust understanding of how the RCMP's response played an unfortunate, but very tangible role in the devastating losses suffered during the Mass Casualty, during its aftermath, and as family members navigated the unimaginable loss of their loved ones.

PART II – ISSUES

5. Our submissions will address the following five broad topics, some of which had a direct impact on Kristen's (and other victims') untimely and preventable death:

    i. RCMP Accountability and Members' Decision-Making Autonomy;
    ii. Resource Issues - Pictometry;
    iii. Communication Failures – Alerting and Strategic Communications;
    iv. Law Enforcement Education; and
    v. Post-Event Support for Family Members.

PART III – DISCUSSION

RCMP ACCOUNTABILITY AND MEMBERS' DECISION-MAKING AUTONOMY

RCMP Accountability

6. It is clear the RCMP's organizational structure and culture played a significant role in the outcome of events on April 18-19, 2020. Critical to restoring confidence for Nova Scotians and Canadians is ensuring meaningful recommendations are made and the RCMP are held accountable to swiftly and purposefully action recommendations to protect Canadians in the future; this is a concern shared by the RCMP's own members.

7. Cpl. Tim Mills was the ERT Team Leader on April 18-19, 2020. Now retired, Cpl. Mills was a seasoned RCMP veteran with over 29 years of service, including participation in ERT's response during the Mayerthorpe and Moncton tragedies. In his evidence, Cpl. Mills expressed poignant concerns about a perceived futility that recommendations stemming from this Commission will not result in meaningful change:

> *…So Moncton was somewhat similar, but not to the scale of this, and things never got rectified that were identified in … the MacNeil decision, and that's where my frustration was voiced…in my belief that, you know, nothing will change after this either. So, you might get a couple little changes out of it … I was an ERT member during Mayerthorpe and seeing all them recommendations, hardly seen any changes. I worked Moncton and seen all the recommendations, hardly seen anything. So my belief in what will come in this after the fact and if it will be followed up if they did, you know, follow up with recommendations, I don't have a big belief in that.*[1]

8. We share Cpl. Mills' concern that recommendations from this Commission will not be actioned or implemented by the RCMP. The evidence before the Commission supports a reasonable conclusion that recommendations flowing

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[1] Cpl. Tim Mills' Evidence, May 16, 2022, pg. 134.

from a variety of past RCMP Reviews, Reports, Inquiries, and Investigations have had challenges with implementation and execution.

9. We anticipate the Federal Department of Justice will submit recommendations are dutifully implemented by the RCMP following reviews and inquiries. In reality, this only appears to be the case on "paper". In contrast, many RCMP members responding to the Mass Casualty were unaware of relevant recommendations and/or the public safety background related to them.

10. This is despite evidence from RCMP Senior Management, who assert recommendations are viewed as "*part of ongoing learning*" with a requirement for Members to read the reports[2]. Additionally, one pre-existing RCMP report in evidence before the Commission directly states "*this is not a one-time read or nice to have, it's the very core of frontline policing in today's environment*"[3].

11. Problematic decision making related to communications and [largely non-existent] roadblocks/check points are directly applicable to the Mass Casualty. Notwithstanding several other possible examples, we submit the following two specific examples highlight the fact that, had relevant pre-existing recommendations been implemented, it is reasonable to conclude they would have had a direct impact on minimizing the number of lives lost and the ultimate outcome of the Mass Casualty.

Members' Decision-Making Autonomy & Communication

12. While there will always be a chain of command, Members operating within that chain should be given autonomy for decision making during critical incidents where seconds are precious to avoid the loss of life.

13. The '*C3 Command, Control and Communications Response and Planning Guide*' was prepared by Criminal Operations Officers ("CrOps") in the Atlantic

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[2] Supt. Darren Campbell's Evidence, July 25, 2022, pg. 28
[3] C3 Atlantic Regional Council Of Criminal Operations Officers – Best Practices and Lessons Learned from Major Incidents throughout North America – Exhibit 1677

provinces and based on best practices and lessons learned from major police incidents throughout North America in the fall of 2015 (the "C3 Guide")[4].

14. H-Division's former CrOps officer, C/Supt. Marlene Snowman, was one of four authors of the C3 Guide. Her successor, C/Supt. Chris Leather, took over in 2019. He had no knowledge of the C3 Guide until after the Mass Casualty, when it was brought to his attention in 2021 because of production requirements for the Commission[5].

15. The Guide is predicated on a principle of C3 leadership, the basis of which is:

> *receiving information, making timely decisive decisions, and communicating these decisions as direction to those entrusted to carry out the action as well as receiving feedback about that action.* ***C3 is less consultative than other forms of leadership simply because "urgency of action" often does not permit consultation.***
>
> (Emphasis added)

16. C/Supt. Leather agreed that C3 Leadership would have absolutely applied to the Mass Casualty response[6].

17. The bureaucracy of the RCMP naturally serves to incumber independent decision making. This was clear on April 18-19, 2020 when multiple people were required and/or involved in the decision-making process, which translated into a blurred and quite frankly confusing command structure for members and the public.

18. No more poignant example of this issue is the evidence related to the drafting and dissemination of the critical tweet that included details of the Perpetrator's car, ultimately posted to Twitter at 10:17 a.m. on April 19, 2020. The creation and dissemination of the tweet involved tasking, delegation, input, drafting, and approval between seven people over a more than two-hour period.

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[4] Ibid.
[5] C/Supt Chris Leather's Evidence: July 28, 2022, pg. 97-98.
[6] C/Supt Chris Leather's Evidence, July 28, 2022 pg. 99-101

19. The evidence overwhelmingly supports the conclusion that Kristen, aware of the Portapique shootings, was actively following the situation and taking steps to ensure her family and work colleagues were aware and safe. Shortly before 9:00 a.m. on April 19, 2020, Kristen posted a link from the RCMP's Twitter page on to the Facebook group "Local 35 Home Support Workers" and wrote "*anyone working in D5 and 7 please be safe and keep your eyes open*"[7].

20. By 9:37 a.m. on April 19th, Kristen's phone records indicate she received a Facebook screenshot from Mr. Beaton, which included the Perpetrator's name, his photo, identifying details, and that he was the RCMP's suspect in the Portapique shootings[8]. She was sitting in her car, parked on Plains Road, in Debert, while she searched online and through social media for additional information about the Perpetrator and his whereabouts.

21. Unfortunately, Kristen was not aware the Perpetrator was wearing an RCMP uniform and driving a RCMP vehicle, identifiable by the call sign '28B11'.

22. The information Kristen was seeking to protect herself had been in the hands of the RCMP since 7:15a.m.-7:27a.m.[9] By 8:00 a.m., direction was given by S/Sgt Halliday and S/Sgt MacCallum to communicate the details of the Perpetrator's decommissioned police vehicle and RCMP uniform to the public, understanding how crucial this information was[10].

23. By 9:40 a.m., RCMP Communications' team member, Cpl. Jennifer Clarke, had drafted the tweet and sent it to S/Sgt MacCallum for approval. When she did not hear from him, she forwarded it to S/Sgt Halliday at 9:45 a.m. for immediate approval, which she subsequently received by 9:49 a.m. However, Cpl. Clarke did not move forward with posting the tweet. Instead, she sought a further level of approval from Ms. Lia Scanlan, a civilian member of the RCMP Communications team. This approval came 28 minutes later at 10:17 a.m.[11] In

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[7] Foundational Document: Plains Road, Debert: para 61
[8] Foundational Document: Plains Road, Debert, para 63
[9] Foundational Document: RCMP Public Communications, April 18–19, 2020, para 60
[10] Foundational Document: RCMP Public Communications, April 18-19, 2020, paras 61-64.
[11] Foundational Document: RCMP Public Communications, April 18-19, 2020, paras 92 – 94, 102

the intervening period, Kristen and Heather O'Brien were murdered by the Perpetrator shortly after 10:00 a.m.

24. The amount of time it took to draft the tweet after S/Sgt Halliday's initial direction was inordinate – over 1 hour and 40 minutes. Similarly, and despite approval being given, there was a 28-minute delay in posting the tweet because Cpl. Clarke sought additional approval based on an assumed "*rule of thumb*" requiring "*more approval for bigger events*"[12].

25. Cpl. Clarke stated said "rule" was not based on any written policy or procedure and testified:

> …[rules] *weren't written down, the rules were understood… and that was definitely something that I understood while I worked there was that if the higher profile the incident, the more approval was required. And there was no way I was going to send that Tweet without her [Lia Scanlan] knowing what I was doing.*

26. It is clear from Cpl. Clarke's evidence that she did not feel she had the autonomy despite being given approval by S/Sgt. Halliday to disseminate the critical tweet.

27. This process during a critical incident is unacceptable. Every second is crucial to avoid loss of life. In this case, it is more than reasonable to assume that had the tweet gone out in a timelier fashion, those who were actively using their computers/phones to search for information, like Kristen, would have been empowered to protect themselves and survive.

28. C/Supt. Leather agreed the significant delay in sending the tweet with description of the Perpetrator's decommissioned cruiser, caused by Cpl. Clarke's understanding that she had to seek an additional level of approval, was an example of where the C3 Leadership Model should have prevailed to

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[12] Cpl. Jennifer Clarke's Evidence – June 7, 2022, pgs 49, 67

remove unnecessary levels of approval[13]. It is very concerning that C/Supt Leather had this understanding, but Cpl. Clarke did not.

Roadblocks/Checkpoints

29. The establishment of roadblocks/checkpoints during the Mass Casualty was, at best, reactive and in some cases too little too late.

30. As outlined in the evidence, we understand the responsibility for establishing checkpoints during a critical incident is that of the Critical Incident Commander[14]. The evidence of S/Sgt. Jeff West, the Critical Incident Commander on duty on April 18th, confirmed the purpose of checkpoints was to monitor entry and exit points of major transportation routes where a suspect may be going[15] and to monitor traffic looking for a suspect's vehicle[16].

31. At 11:00 a.m. on April 19th, the Perpetrator travelled from northern Nova Scotia into Southern Nova Scotia at a major entry/exit point that could have been easily monitored by a checkpoint. As early as 7:00 a.m., the RCMP had credible information from Lisa Banfield that the Perpetrator intended to travel to the Halifax-area where her sister lived. No steps were taken to action a checkpoint at this critical and major transportation route.

32. At 2:20am on April 19th, it was known the Perpetrator had family in New Brunswick and had previously threatened to kill them. It was also known the Perpetrator had a residence in Dartmouth, Nova Scotia. Halifax Regional Police established a perimeter around the Perpetrator's Dartmouth residence[17]. A checkpoint was also established at the Cobequid Pass[18]. However, S/Sgt West had no awareness of any checkpoints established as of 2:20am[19].

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[13] C/Supt Chris Leather's Evidence: July 28, 2022, pg. 100-101
[14] Cpl. Tim Mills' Evidence, May 16, 2022, pg. 136
[15] S/Sgt Jeff West's Evidence, May 18, 2022, pg. 181
[16] Ibid
[17] Foundational Document: RCMP Command Post, OCC, and Command Decisions – para 272.
[18] Foundational Document: RCMP Command Post, OCC, and Command Decisions – para 273.
[19] S/Sgt Jeff West's Evidence, May 18, 2020, pg. 180

33. As referenced above, Lisa Banfield advised ERT members at 6:44 a.m. on April 19th of an express intention by the Perpetrator to kill her sister in Dartmouth[20]. While steps were taken to ensure Ms. Banfield's sister was removed from her house, nothing was done to establish a checkpoint at the Truro/Bible Hill highway intersection, a route the Perpetrator would need to travel to move from Northern, Nova Scotia, towards Halifax. S/Sgt West acknowledged this was an intersection that could have been covered by an officer in a mobile unit[21]. Nothing was done by RCMP to action a checkpoint in this area, despite knowing the Perpetrator expressed an intention to travel to the Halifax-area to cause physical harm.

34. Finally, at 9:42 a.m., the RCMP were aware of an RCMP vehicle being spotted near the scene of a deceased female in Wentworth. Witnesses noted the cruiser "*left to head to Truro*"[22]. Again, no steps were taken to action a checkpoint at the Truro/Bible Hill intersection. Instead, all available RCMP members were directed to the Glenholme, and later the Plains Road area, with no direction or foresight to monitor an entry and exit point on a major transportation route that was known to be a route the Perpetrator would have to travel[23].

35. As a result, shortly before 10:15a.m., the Perpetrator drove unnoticed through an obvious and predictable major entry/exit point that could have been easily monitored by a checkpoint.

36. The failure to action such a checkpoint was even more egregious considering recommendations flowing form the 2014 MacNeil Review. The MacNeil Review[24] was authored in response to a mobile shooter event in Moncton, New Brunswick in June 2014. The detailed review contained many recommendations, including a section on "*Supervision during the Entire Incident*".

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[20] Foundational Document: RCMP Command Post, OCC, and Command Decisions – para 397
[21] S/Sgt Jeff West's Evidence, May 18, 2022, pg. 182
[22] Foundational Document: RCMP Command Post, OCC, and Command Decisions – para 539
[23] S/Sgt. Jeff West's Evidence, May 18, 2022, pg. 186.
[24] Exhibit 1622

37. Section 3.6 of the MacNeil Review recommends that "*where it does not already exist, each Division establish 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*".

38. The "*RCMP Update – Implementation of the MacNeil Recommendations – January 2020*"[25] summarizes the status of the MacNeil Review recommendations four months prior to the 2020 Mass Casualty and notes the Detachment Emergency Operational Plans had been amended to address this recommendation. Despite this, neither Critical Incident Commanders S/Sgt West or S/Sgt Surette were aware of this recommendation or of an Emergency Operational Plan being developed to identify entry/exit points and major transportation routes.

39. S/Sgts West and Surette did <u>not</u> receive any training or instruction on the MacNeil Review. What they had read was at their own initiative. They were unaware of whether the MacNeil Recommendations were implemented in Nova Scotia or whose role it was to implement them. S/Sgt Surette received his Critical Incident Training in 2015, after the MacNeil Review was authored, and did not recall any portion of the MacNeil Review being part of his Critical Incident Commander training[26]. In fact, the MacNeil Review was never presented to any of the Incident Commanders in Nova Scotia[27].

40. We fundamentally believe the failure to implement this recommendation in practice had a direct impact on the events and deaths that followed after the Perpetrator passed through Truro, Nova Scotia.

41. Understandably, public trust in the RCMP has eroded significantly because of the Mass Casualty. This trust has been further eroded by the realization that

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[25] Exhibit 3928
[26] S/Sgt Kevin Surrette's Evidence, May 18, 2022, pg. 190
[27] S/Sgt Kevin Surrette's Evidence, May 18, 2022, pg. 190

recommendations have not been meaningfully actioned in Nova Scotia despite prior reviews of the RCMP's actions following active shooter events.

42. The Commission's recommendations are the result of the hard work done by all those involved in the Commission. Such recommendations, and how they are actioned, will form the legacy of the April 2020 tragedy, and the legacy of those whose lives were lost. If there is no confidence or faith in the recommendations being meaningfully actioned/implemented, this work and the deep losses suffered by the families will all be for not. We submit, such an outcome cannot be the legacy left by the Commission and its work.

43. Further, the implementation of the Commission's recommendations amount to lip service if Members are not fully informed, educated, and trained on the changes. Education must be built into the Commission's recommendations from a structural perspective. To that end, we make the following submissions:

    i. A Provincial Implementation Committee be struck to ensure recommendations made and then implemented are not lost with the passage of time and/or a change in government. Such a committee should be comprised of representation from all stakeholders but specifically with respect to the RCMP, representation from National Headquarters, H-Division senior command, Critical Incident Commanders, ERT/EMRT, and, most importantly, representation from those most affected by the Mass Casualty (including victim's family members/representatives)[28]. It is also suggested that the mandate of the Committee include preparation of an annual report updating the public on the implementation/execution of the recommendations, with an accompanying website;

    ii. Mandatory Member training based on the recommendations relevant to the RCMP within the Commission's report;

    iii. Mandatory and ongoing Member training based on the Commission's recommendations for specific positions requiring higher/specialized training, i.e., Critical Incident Commanders, ERT, EMRT, Risk Managers;

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[28] Retired Assistant Commissioner Lee Bergerman agreed this would be a good idea – Evidence, August 22, 2022 at pgs.129-130

iv. Creation of a special continuing education body to train RCMP Members/Management on recommendations made in the Commission's report, as well as insight from future reviews; and

v. Mandated onboarding of senior Divisional and Detachment leadership across Canada, including a briefing binder, checklists, and in-person transitions (a recommendation from C/Supt Leather). The briefing binder should include a section with reviews, and recommendations specific to that individual's position.

RESOURCE ISSUES

44. The evidence highlights significant issues with RCMP resources, ranging from resources that were not available, to those available but not accessed in either a timely manner or at all. As a result, RCMP Members' ability to respond in an optimal way on April 18-19, 2020 was significantly and adversely impacted.

45. Rectifying some of these resource issues will take funding. Other resource issues will take training. Members cannot be set up for success if they are not provided with the right tools for the job; this includes knowing the full extent of the tools in their toolbox.

Pictometry

46. Colchester County is the second busiest county for policing outside of the Halifax Regional Municipality. During the relevant period there were between 4-6 members on duty in Colchester. These members were responsible for covering a significant expanse of rural territory. Evidence confirms responding Members had limited, if any, familiarity with the Portapique area.

47. On April 18, 2020, all available officers (four) were dispatched to Portapique. Three of these members engaged in an 'Immediate Action Response Deployment' ("IARD") response, as they entered the community in search of the active shooter.

48. Once these officers entered Portapique on foot, they did so largely blind. They had no night vision goggles and no access to working maps while on foot. They resorted to using their personal cell phones to identify various locations within the community.

49. Based on the Commission's working timeline, the four responding officers arrived in sequence from 10:25:27 p.m., with Cst. Dow arriving at 10:43 p.m., and the Perpetrator allegedly leaving the community at approximately 10:45 p.m. These Members had the best opportunity to identify and apprehend the Perpetrator. With IARD the Members' focus, their immediate priority was to locate and neutralize the Perpetrator. However, their ability to do so was significantly hampered by a lack of resources, a key one being visibility on the access points into and out of the community.

50. The initial responding Members, and all those who followed thereafter, understood there was only one way in and out of Portapique. This error was perpetuated by the Risk Manager and OCC who relied on outdated mapping technology, which in turn left responding members with incorrect information pertaining to perimeter containment in Portapique. The reliance on outdated mapping was unnecessary because Members had access to Pictometry (mapping technology) that clearly showed the alternate access through the Blueberry Field Road; this technology was not accessed by Members critical to the RCMP's response to the Mass Casaulty[29].

51. S/Sgt. Halliday agreed in his testimony that access to Pictometry "*would have provided a more clear view of what we were dealing with in terms of geography and topography*"[30].

52. There were varying reasons why Pictometry was not used on April 18, 2020. Members, including S/Sgt Carroll, appeared to have limited, if any, understanding of how to use Pictometry. Similarly, Ms. Jennifer MacCallum and Risk Manager S/Sgt Rehill at OCC had challenges accessing it.

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[29] Supplementary Investigation Report – Pictometry, Exhibit 1546
[30] S/Sgt Steve Halliday's Evidence, May 17, 2022, pg. 37

53. S/Sgt. Briers was an example of Member who was well-trained in Pictometry and had used it frequently prior to the Mass Casualty. One can reasonably assume that had S/Sgt. Briers been the Risk Manager on the evening of April 18th, he would have accessed Pictometry to identify and direct successful containment of Portapique in a timely manner.

54. The use of Pictometry on April 18-19, 2020 should have been non-negotiable. Its value is even greater in a rural policing environment where street signs, mapping etc., are not as prevalent. What Nova Scotians expect, and what the RCMP must insist upon, is having Members well-trained in all available technology and to use said technology regularly. <u>This costs nothing.</u>

55. We submit that had this key tool been activated at the start of Members' shifts, it is reasonable to conclude that any IT issues could have been addressed well in advance of the 10:00 p.m. 911 calls from Portapique.

56. We submit the following recommendations for consideration:

    i. Mandated training for all RCMP Members, regardless of their rank, on the use of Pictometry (or any other enhanced mapping technology available to Members). It is imperative that Members policing rural areas be fully operational in their use of Pictometry;

    ii. RCMP must ensure updated and integrated mapping and pictometry systems are available on Members' Mobile Works Stations ("MWS");

    iii. Enhanced IARD training with a particular focus on rural (mimicking the area Members serve), nighttime, and mobile shooter events, with Pictometry being mandated as part of related training and tabletop exercises; and

    iv. Ms. Banfield indicates she escaped from the Perpetrator by "sliding through the window in the silent patrolman" and exiting the mock cruiser[31]. For officer and public safety purposes, we submit these barriers should be

[31] Foundational Document: Portapique April 18-19, 2020, para 66.

reconfigured to ensure individuals are not able to unlawfully exit police cruisers.

Threat Assessment Coordinator

57. The implementation of a 'Threat Assessment Coordinator' is necessary, as was identified in the report flowing from the Mayerthorpe Tragedy. While we will never know if a Threat Assessment Coordinator would have changed the outcome of the Mass Casaulty, it is clear the Perpetrator would have been on the radar of this position, as he was not completely unknown to the law enforcement. Of note, the Perpetrator had the following history with law enforcement, including:

    i. Charges resulting from the 2001 assault of a teen;

    ii. A known history of purchasing decommissioned police vehicles from GC Surplus. The Perpetrator shared his intention to remodel/restore vehicles to RCMP likeness. Yet, this raised no red flags for the employee who knew it was illegal to impersonate law enforcement;

    iii. 2011 death threats made by the Perpetrator against his parents. This placed the Perpetrator on the radar of Halifax Regional Police. The RCMP should have been aware of this information given Sgt. Poirier asked Cst. Wiley (RCMP Member) to follow up with the Perpetrator to review what, if any, firearms were in his possession;

    iv. 2011 CISNS Officer Safety Bulletin detailing the Perpetrator's threat to kill a police officer and that he was reportedly extremely dangerous. Again, nothing appears to have been done to investigate the Perpetrator;

    v. Brenda Forbes' 2013 report to police about the Perpetrator's illegal firearms. While there is conflicting evidence before the Commission on this event, what is clear is Cst. Maxwell's existing notes are very sparce; and

vi. Canadian Border Service Agency flagging the Perpetrator for possible smuggling of drugs and firearms into Canada.

58. The success of the Threat Assessment Coordinator position is predicated on good intelligence. Good intelligence can only exist if the intelligence pertaining to an individual, including officer's notes and officer safety bulletins, is robust at the onset, preserved, and subsequently shared where necessary. We submit the following, recommendations:

    i. Member notebooks to be scanned upon completion and updated to internal RCMP systems;

    ii. Member notebooks to be scanned prior to transfer out of the Division;

    iii. The period for internal purging of notebooks and PROS files be extended; and

    iv. A system be devised for proper and consistent inter-agency distribution of Safety Bulletins to law enforcement.

COMMUNICATION

Failure to acknowledge witnesses' reporting of the Perpetrator and relevant situational information on April 18-19, 2020

59. To quote George Bernard Shaw, "*the single biggest problem in communication is the illusion that it has taken place*". We submit this statement is highly relevant to the Mass Casaulty.

60. The volume of information received by the RCMP on April 18-19, 2020, as well as how it was gathered and shared with others, was a significant issue. It is clear from the evidence that systems and Members did not communicate efficiently.

61. The problem with information sharing started with the first 911 from Jamie Blair at 10:01a.m. and continued throughout the remainder of the Mass Casaulty. Highly relevant details about the Perpetrator were relayed by Jamie Blair, Andrew and Kate MacDonald, and the Blair and McCully children within the first 30 minutes, including identifying markings on his vehicle. This important information was not meaningfully captured and/or disclosed to responding Members or subsequently to those in command.

62. No one was provided with a summary of the initial 911 calls or was able to listen to the 911 calls first-hand. ERT was stood up at 10:45 p.m. on April 18th and on the road from Halifax at 11:20 p.m. However, the team did not receive any pertinent information about the Perpetrator until they reached Truro, which would have been sometime after midnight.

63. Information about an alternate access route out of Portapique was provided to Cst. Vicky Colford by Kate MacDonald. Cst. Colford conveyed this information over the radio but was not met with any acknowledgment or action in response, nor did she follow up on her message.

64. Important information was provided to the RCMP in various ways (911 calls, live interviews, etc.), yet this information was not shared competently, or in some cases, at all.

65. A key area for consideration is to determine what can be done to ensure proper communication processes are in place so that large volumes of information can be accurately passed down the line to those individuals who need to make informed decisions and give precise orders.

66. As a starting point, and specifically with respect to a critical incident, a key recommendation is that a specific individual be tasked to review 911 calls in a timely manner to compile a detailed list of key information which can then be used to accurately brief others from that point forward. This avoids the effect of "telephone" where critical information is not properly captured and/or lost, as

multiple individuals interject and convey their own perspectives, which in turn, dilutes the original information.

Flawed Strategic Communication Processes

67. Despite the availability of three communication methods (media releases, social media, and Alert Ready), the RCMP only employed social media to alert the public of the active shooter event.

68. As a starting point, the RCMP's reliance on social media as the sole manner of communicating details about the Perpetrator and the danger to Nova Scotians was a restricted manner of communication. Reliance on Twitter and Facebook automatically excludes a significant portion of Nova Scotians. To that point, despite being Director of Strategic Communications for H-Division, Ms. Lia Scanlan gave evidence that she does not personally use Twitter, nor does she have a full understanding of its function, features, and use[32].

69. Evidence from Cpl. Clarke and Ms. Scanlan leads to the easy conclusion that the social media strategy was flawed on many levels. Their evidence confirmed Members were/are paralyzed by red tape, processes, and the formalities of command structure on one hand, while lacking necessary policies and training on the other. There was a constant cycle of chasing, checking, and correcting which led to waste, error, and a delay that was directly relevant to Kristen's death.

70. The <u>only</u> public communication available to Nova Scotians on social media from 11:00 p.m. on April 18th to 10:03 a.m. on April 19th was that the RCMP were investigating a "firearms complaint" in Portapique. This message was wildly misleading and gravely understated the reality of what had happened, as well as what the already RCMP knew.

71. Communication issues continued in the aftermath of the Mass Casualty. The RCMP's Operational Manual on Media Releases states that public

[32] Ms. Lia Scanlan's Evidence, June 8, 2022, pg. 93

communication should "*report only the facts*"[33]. In reality, the public got limited, inaccurate, and incomplete information. The 6:00 p.m. press briefing on April 19th made no mention of the deaths of civilians; this information was only elicited as a result of a media question. Further, the response provided was knowingly incorrect, as the RCMP downplayed the true death toll (at least 10 versus 17).

72. The failure of the RCMP to be transparent and provide *the facts* has added to the public's loss of confidence and fundamental mistrust of the organization.

Alert Ready System

73. The fact that none of the responding command structure was aware of the availability of the Alert Ready System is astounding. The default response by RCMP Management during proceedings has been that "Alert Ready was not a tool in the toolbox", as they were completely unaware its use was an option. The RCMP's position in this regard is incorrect and unacceptable based on clear evidence that an intrusive alert option for active shooter situations was presented to the RCMP many years prior to April 2020, and as early as 2012.

74. The evidence confirms former S/Sgt. Mark Furey sent a briefing note to CrOps in 2012 related to public alerting. His note identified three categories of alerts, including an "intrusive alert", which could be issued where there is an "immediate or potential risk to life[34]. Former S/Sgt. Furey's evidence was not well received or supported by the RCMP and ultimately led to his departure form the force.

75. Similarly, EMO's Paul Mason gave a 2016 presentation to the RCMP wherein the potential use and benefits of the Alert Ready System where outlined[35]. Mr. Mason's experience was consistent with Former S/Sgt. Furey's, as it appears the benefit of the system was not acknowledged by the RCMP.

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[33] Exhibit 2580, pg. 1
[34] Mark Furey Response to MCC Questions, August 22, 2022 - #8
[35] Paul Mason, EMO, Alert Ready presentation, June 2016

76. Truro and Halifax Regional Police were aware of the availability and utility of Alert Ready. On its own initiative, EMO mobilized and was ready to engage an alert on the morning April 19th. The only entity seemingly unaware of the availability of the Alert Ready System was the RCMP.

77. The fact the RCMP chose to ignore the availability of Alert Ready is a bigger issue than just the impact it had on public safety on April 18-19, 2020. It suggests the RCMP was wilfully blind and made a choice not to adopt or learn more about this system; a system that we submit is an asset to law enforcement.

78. The RCMP had a duty to warn the public but failed to do so. In fact, if Mrs. Beaton was apprised of the true magnitude of the situation, we submit she would not have left for work on the morning of the 19th. As such, it is more than reasonable to assume the loss of innocent lives would have been less had an alert gone out on the morning of April 19, 2020.

79. It is comforting to know Nova Scotia RCMP now have 'trusted user' status for issuing public alerts. It was also reassuring to see the RCMP use public alerting in the recent James Smith Cree Nation and Weldon tragedy. However, it was very disappointing to hear C/Supt. Leather's response to the following question: "*...if the same exact events happened today with the new policy and protocols in place would an alert be issued?*", his answer being:

> *It's a very difficult question to answer because, unlike the principals that were in command, Halliday, MacCallum, West, Surette, the issue of alerting in a situation that would have been fraught with risk for both the public and the police and I think me opening that up is irresponsible because I wasn't there, and it is not clear-cut that an alert would have been the right tool to be using*[36].

80. After all the evidence the Commission has heard, including the timeline of information known by the RCMP through the early morning hours of April 19,

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[36] C/Supt Leather's MCC Statement July 6, 2022, pg. 125

2020, and Michael Hallowes' detailed evidence on the use of public alerting in Australia, we ask that the Commission make a finding of fact that the events of the Mass Casualty should have necessitated an alert well before the Perpetrator became known to be active at 9:30 a.m. on April 19, 2020.

81. As a trusted user in Nova Scotia, the RCMP should take responsibility to spearhead a public education campaign alongside EMO and the provincial/federal Department of Justice. We submit such a campaign should include use of the RCMP's website to distribute information to the public about the system's function (as reviewed by Mr. Hallowes, Australian Public Alerting Expert).

82. We submit the following recommendations also be considered by the Commission:

    i. Clear and practical written guidelines outlining the public alerting process for RCMP Command and Strategic Communications team;

    ii. Strategic Communications' Member be embedded into Command Post/stood up with Critical Incident Response team;

    iii. Designated Member/individuals from Strategic Communications to continuously monitor and/or updated social media accounts during critical incidents (as appropriate);

    iv. Designated Member/individuals from Strategic Communications to liaise with and update media for the purpose of broadcasting critical public safety information through those mediums; and

    v. Mandatory public relations/communications training (courses) for RCMP Command.

LAW ENFORCEMENT EDUCATION

83. We have heard that policing has changed significantly over the last few decades. This was covered significantly in the June 30, 2022 Roundtable on Rural Community Safety and Policing.

84. Supt. Dan Morrow, a Member with 30 years of policing experience, shared his observations about the change in policing, stating[37]:

> *We often look at the training equipment, the technology that's required for police to do their jobs effectively and safely. And in those 30 years, the landscape has completely changed. Our training has been ramped up in order to meet the demands on the crimes that have escalated. You know, before, when I joined, I didn't know what a cellphone was, or an email. Now we are responding to calls for service that actually originate from international jurisdictions as cyber offences have increased, targeting our elderly and our youth. Same with equipment. The technology, again, ever changing, hard to keep pace with. And the costs have increased significantly.*

85. Dr. Rick Ruddell addressed the expansion of expectation for the law enforcement over the last number of years[38]:

> *What we're seeing the past few years is a decrease in the public's trust/confidence and their perceptions to the performance of the police, and some of those issues were brought up by Dan. I mean, he was talking about the complexity of the job has increased, the expectations of the public have increased, and the public…the expectations are higher, their perceptions are lower.*

86. Dr. Jane McMillan addressed the inevitable erosion of community trust when expectations of services are not in line with what law enforcement can provide[39]:

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[37] June 30, 2022 Roundtable Evidence, pgs 82-83
[38] June 30, 2022 Roundtable Evidence, pg. 85
[39] June 30, 2022 Roundtable Evidence, pg. 97

> *Well, the significance of resources, the significance of anticipating community expectation and community demands. So being able to understand the underlying issues of when a community is going to want to engage with police.*
>
> *I think the question of community expectations is a critical one to be able to master, because if you've got a demand for police services that aren't actually going with what the police can actually do and offer and you're -- the trust issues are going to disintegrate really rapidly.*

87. Dr. Signa Daum Shanks also spoke about the need for enhanced training on the law for RCMP Members[40].

88. While much has changed in policing (law, technology, the complexity of issues, and public expectations), the timeframe for new Member education at Depot is still six months. This raises the fair question of whether the current education program at Depot is sufficient ensure public safety for Canadians.

89. Mr. Kimmo Himberg, retired Rector of the National Police University College in Finland, indicated at the June 1, 2022 "Critical Incident Response" Roundtable that each Finnish officer completes a minimum of three years' training at the university before they are enrolled in the Finnish police force[41]:

> *In Finland, according to international measurements, public trust, citizen's trust to the police is the highest in the world, according to the latest police barometer, 91 percent of Finnish citizens trust the police a lot or close to that.*
>
> *Why is that? Our understanding is that one of the reasons is that we educate officers extensively. Basic police education leads to a bachelor degree in policing and takes three years. There is a lot of -- more theoretical and practical content in the program and we put a special emphasis on values and attitudes in the education.*

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[40] June 30, 2022 Roundtable Evidence, pg. 128
[41] June 1, 2022 Roundtable Evidence, pg. 5

90. The Commission must pay attention to the correlation between society's trust in law enforcement and enhanced education and training.

91. We submit the following recommendations be considered by the Commission:

    i. Expanded training requirements, including additional time at RCMP Depot and/or more focused and specialized training thereafter;

    ii. Monthly Municipal Police Advisory Board meetings to ensure negative feedback is received as quickly as possible, allowing for timely responses and necessary changes to be made; and

    iii. Detachments, particularly in rural and remote areas, should provide an orientation package to newly trained Members and those new to the detachment (even for experienced Members). Supt Dan Morrow noted this was done in some detachments, with others conveying the informational orally[42].

POST-EVENT SUPPORT FOR FAMILY MEMBERS

92. The importance and sensitivity of family management was addressed in the January 13, 2020 "*Independent Administrative Review of the "F" Division RCMP investigation relating to the Homicide of Mr. Colten Boushie*"[43]:

> *In general, a homicide victim's family often experience a great deal of uncertainty about an investigation, as protecting its integrity obligates police to withhold detailed information from all people. The family may have to endure media pressures, public rumour, and speculation about circumstances surrounding their loved one's death. The victim's family may have to process their grief all the while coming to terms with the perhaps unexpectedly long periods of time that are required for complex homicide investigations to properly complete. All of these things can create stress for the family and in general terms, can potentially undermine their confidence in the police and their support for the police investigation. A* ***purposefully built trustful relationship***

[42] June 30, 2022 Roundtable Evidence, pg. 122
[43] Exhibit 4214, pg. 76

between the police and the family will generally facilitate better communication within these context of grief, stress, lack of information and uncertainty.

(Emphasis added)

93. A significant amount of the families' post-tragedy grief centered on the lack of transparency, insufficient information, or support from the RCMP. **It is safe to say a purposefully built trustful relationship between the families and RCMP did not exist.**

94. Family members reeled in the immediate aftermath of the Mass Casualty when they learned of the loss of their loved ones. Their trauma was magnified by the way the RCMP communicated with families, handled next of kin notifications, provided sub-optimal family liaison services, and insufficient crime scene management.

95. Cst. Wayne Bent was the sole officer assigned to act as family liaison officer for all victims' families. He had no training specific to this role and, at least in the days immediately following the tragedy, he was also tasked to complete other duties. While the RCMP offered to have another Member assist, Cst. Bent declined.

96. In contrast, Cst. Heidi Stevenson's family were provided with two liaison officers – one for her parents and one for her husband and children. Ms. Lisa Banfield also had a specific officer assigned to her post-event.

97. The experiences of the Beaton Family and others navigating the aftermath of the Mass Casualty is gut wrenching. The flow of information from the RCMP was significantly lacking, leaving families to search through social media for pertinent information. Families also called 911, the RCMP, and Truro Police repeatedly.

98. The Beaton family's experience includes, but is not limited to[44]:

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[44] Foundational Document: Information Seeking from Families and Next of Kin Notifications, paras 252-271

i. Their efforts to locate Kirsten began before 11:00 a.m. on April 19, 2020. Her brother, Mr. Richard Roode, drove to the scene of her death shortly after 11:00 a.m. to provide information about Kristen, including her name and the car she was driving. Mr. Roode provided his contact particulars so that RCMP could follow up with him, but no one did;

ii. At 11:32 a.m. Kristen's husband, Mr. Nick Beaton, called 911 to inquire about her whereabouts. He was told the information would be forwarded to Members on the ground who would follow up with him;

iii. At 11:48 a.m. Kristen's employer called 911 to report her missing and to provide details of the vehicle she was driving. Her employer was able to track her work phone, which showed her last location as of 9:50 a.m.; and

iv. At 12:49 p.m., the RCMP confirmed with Kristen's employer that she was no longer missing. Despite this, Kristen's husband and family members did not receive confirmation of her death until 6:00 p.m. that evening. Her husband was told he would be "happy" to know he was one of the first ones to learn of his loved one's death. He waited eight hours to officially learn what he feared the most, notwithstanding the RCMP having learned this information hours earlier.

99. Other families encountered similar experiences, which included:

i. Official next of kin notification not happening until April 20-22, 2020(Zahl/Thomas family, Madsen/Gulenchyn family, and the Bond family). Unfathomably, the Goulet family has yet to receive an official next of kin notification related to Ms. Gina Goulet's death; and

ii. Some family members, including Mr. Dan Jenkins and Ms. Michaella O'Brien, had guns drawn on them when they attended to the scene to find

out information about their loved ones. The Perpetrator's face and identity were well known to RCMP at that point, so there would be no relevant safety concerns or risk of mistaken identity.

100. In the days that followed, the Beaton family's trauma continued. Although there was a police presence at Kristen's crime scene, it was not secured. As a result, photos and videotape of her uncovered body were taken. Family members had to see multiple pictures and video of her body. Mr. Beaton was left to contact a news outlet on his own to request they remove the footage of Kristen.

101. Further anguish was caused by the RCMP when property was returned to families with crime scene remnants. This was the case for the Beaton family, as they collected Kristen's vehicle with visible signs of her trauma remaining. Again, Mr. Beaton was left to collect and clean Kristen's personal belongings once released by RCMP.

102. The families' experience did not get better due to less-than-ideal communications from the RCMP. Kristen's husband learned much of the detail about what happened to her by watching CTV news broadcasts. He was told by Cst. Bent to turn on the news because new information about the Mass Casualty was going to be released, leaving him to learn this information at the same time as the rest of the world[45].

103. Similarly, the Beaton family was left reeling after Cst. Bent told Mr. Beaton and our client that Kristen's phone, which included priceless photos and videos, could not be returned to them with her other belongs because it was still being reviewed as evidence. In our client's experience, Cst. Bent expressly insinuated to the Beatons that the investigative team was looking into any possible connections, including a romantic/sexual relationship, between Kristen and the Perpetrator. Cst. Bent denied stating this to the Beatons at that time, but did note:

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[45] Summary of Meeting with the Family of Kristen Beaton, Exhibit 2307

> *...I would have told him that we are looking at everything. At that point in time, what is the relationship as to why he [the Perpetrator] was and wasn't looking at certain people. Why some people were chosen and some people weren't chosen. We have to look at everything out there that's a possibility*[46].

As one can imagine, this exchange between Cst. Bent and the Beatons caused a devastating and long-lasting impact on a family that was already suffering significantly due to her loss, especially given Kristen had no connection whatsoever to the Perpetrator. This is further confirmation that Cst. Bent was ill-equipped to deal with families or provide information in a tactful way and/or untainted by his opinion or perception of the facts. It cannot be overstated that anyone designated as a Family Liaison going forward must have significant training to avoid causing more damage to already vulnerable families. Without this, one cannot build a basis of trust or meaningful communication between those most affected and the RCMP following a tragic event (as outlined above in the Boushie Review).

104. We submit helpful guidance from various components of Phase II evidence will combat unnecessary anguish for families following mass casualty events in the future.

105. The June 28, 2022 roundtable *"Understanding and addressing the immediate and long-term needs of those impacted by mass casualty incidents"* evidence is particularly relevant when considering insight and best practices to inform the basis of recommendations for family support[47].

106. The Commission has obtained reports from Dr. Grete Dyb and Dr. Jaclyn Schildkraut which contain empirical research confirming mass casualty events have deep and far-reaching impacts on survivors, families, and communities.

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[46] Cst. Wayne Bent's Evidence, June 8, 2022, pg. 80
[47] June 28, 2022 MCC Roundtable Transcript.

107. The importance of accurate and timely communication was addressed by the panel, and specifically by Levent Altan in his report "*How can the EU and Member states better support victims of Terrorism*"[48]. During the panel, he also reviewed international best practices for victim support and communication[49]:

> *It was mentioned earlier, I think it was Mary, who talked about information. It's not only is a conduit right in the sense that it helps you access other services and rights, but it's fundamental to a person's understanding of what's going on. It can reduce harm or it can increase harm, depending on how you handle your communications.*
>
> *As an example of how not to handle that kind of communication: After the Brussels attacks, the identification of the murdered victims was taking place, and the decision was made, out of the concern for the victims themselves, to not inform family members of the identification of the victims until they were absolutely 100 percent certain. And in one case, the family members were going around hospitals for days looking for their loved one, whilst the coroner or the DVI experts had known 90 percent who the person was. And the trauma of knowing that this -- that the person knew 90 percent and they were still seeking their loved one was extremely harrowing for the family members.*
>
> *So there are other ways of being transparent in informing victims about the situation, about communicating, and that's communication with the public, in general, and then having the communication procedures in place so that you can effectively communicate with the victims as well. And within the concept of communication, within that framework, you're looking at fundamentally how do you communicate, different methods of communication, so different formats, so that you're taking into account the different ways that people will absorb that information, ensuring it's simple and accessible, that it's repeated.*
>
> *We keep hearing this point about proactive as well, and that's proactive in terms of offering support, but also proactive in terms of providing information. People in these traumatizing, chaotic situations, don't know what they want when they need it. We need to keep*

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[48] Exhibit P-002852
[49] June 28, 2022 Roundtable – pgs. 40-42

offering those things in an appropriate manner at different times and in different ways, and that's a fundamental part of the way that we communicate. So communication, you can prepare for and plan for. You can have a lot of the procedures and processes in place. You can even have the structures for a public website. – Netherlands example.

108. Long-term communication needs were addressed by Ms. Mary Fetchet[50]:

…in the early days, the most important thing for everyone is to have accurate information, and you really have to think in terms of, you know, who's communicating that, how can you streamline it, so the right person is giving the right information.. You have to take into consideration holidays, birthdays, the anniversary, and how are you going to support those people during those times. We saw after 9/11, I can't tell you the number of the deadlines that we had that were set around Christmas or around the anniversary when families were really just trying to garner up the strength to get through, you know, a very emotional time for them and their families.

109. The June 28, 2022 panel's collective experience and expertise reinforced:

i. Everyone experiences grief differently with multiple layers, and in their own time (Mary Fetchet)[51] and Megan McElheran[52];

ii. Even with the passage of time, Nova Scotia remains "raw" (Serena Lewis)[53] and as a community, we are still in the early days of recovery (Megan McElheran) with grieving done in a fishbowl (Dr. Jacklyn Schildkraut)[54];

iii. Victims and their families require respectful treatment, recognition, and protection from further harm and secondary victimization (Levent Altan)[55]; and

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[50] June 28, 2022 Roundtable – pg. 25
[51] June 28, 2022 Roundtable – pg. 12
[52] June 28, 2022 Roundtable – pgs. 16-17
[53] June 28, 2022 Roundtable – pg. 13
[54] June 28, 2022 Roundtable – pg. 44
[55] June 28, 2022 Roundtable – pg. 22

iv. Recovery from the trauma of the battlefield is not possible while still on the battlefield (Megan McElheran)[56].

110. Further to the above-noted guidance, we make the following recommendations regarding short and long-term support for family members who experience the loss of loved ones in mass casualty events:

i. The RCMP should have updated procedures for scene security, clean up, and preservation of victim dignity. Crime scenes with victims' bodies still present should be secured and protected such that video footage and photographs cannot be taken;

ii. Victims' bodies should be treated in a respectful manner with a blanket or covering applied immediately after all necessary life saving measures and medical attention has failed;

iii. The RCMP and Nova Scotia municipal police agencies must develop Family Liaison processes and procedure guidelines, and provide Members acting in this role with clear direction, even if they have prior experience in this area;

iv. Members acting as a Family Liaison should be specifically assigned to this role following a critical incident (instead of trying to balance other tasks as was the case for Cst. Bent);

v. Nova Scotia Victim Services should be integrated with RCMP and municipal police agencies Family Liaison role and work collaboratively within a team model to support victims and families;

vi. Nova Scotia EMO, RCMP, and municipal police agencies must develop a dedicated non-emergency line into the Operational Communications

[56] June 28, 2022 Roundtable – pg. 34

Centre for family members seeking updated information in the immediate aftermath of a mass casualty;

vii. Nova Scotia EMO, RCMP, and municipal police agencies must develop a victim-focused communication website with different sections for the public and victims to access relevant information in the immediate aftermath of a mass casualty, similar to the Dutch website referenced by Mr. Altan[57];

ix. Nova Scotia EMO, RCMP and municipal police agencies must develop and tabletop a technology plan to identify and locate victims and survivors of a mass casualty akin to the Belgium "Be Prepared" bracelet program referenced by Mr. Altan[58];

x. Nova Scotia EMO and the municipalities must develop multi-disciplinary crisis teams, including family physicians, psychologists, nurses, and social workers, to contact and support identified victims and families like the process developed in Norway and identified by Dr. Greta Dyb[59];

xi. Recommendations from the January 13, 2020 "*Independent Administrative Review of the "F" Dvision RCMP investigation relating to the Homicide of Mr. Colten Boushie*"[60] related to Family Management, Death Notifications and Crime Scene Management should be reviewed and incorporated into the Commission's report, as appropriate;

xii. Nova Scotia Victim Services must develop and facilitate peer support groups with input from families (similar to those identified by Mary Fetchet and Dr. Jaclyn Schildkraut)[61]. It is critically important that funding be provided to appropriately train those providing peer support to ensure "they're not going to do harm (as noted by Ms. Fetchet)[62];

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[57] June 28, 2022 Roundtable – pg. 41
[58] June 28, 2022 Roundtable – pgs, 42-43
[59] June 28, 2022 Roundtable – pgs. 37-38
[60] Exhibit 4214
[61] June 28, 2022 Roundtable – pgs. 61-68
[62] June 30, 2022 Roundtable – pg. 56

xiii. To the extent possible, the Commission should deliver its report earlier than March 31, 2023 and as far in advance of the anniversary of the Mass Casualty as possible. Only with delivery of this report will the families be able to move from the early days of recovery to no longer being on the *battlefield*; and

xiv. The Commission must review and consider additional precedents for family supports and communication, as identified in Mr. Altan's report.

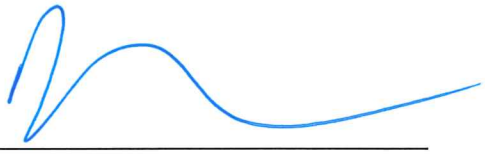
PART IV – CONCLUSION

111. The loss of life and ongoing suffering caused by the Mass Casaulty is unparalleled. However, it is clear that while this event was unprecedented, law enforcement, namely the RCMP, were not properly trained, prepared, or equipped to efficiently respond to this active shooter situation and/or ensure public safety.

112. The Commission must carefully consider and balance the wide breadth of evidence before it, as well as the recommendations made by Participants and subject-area experts alike, to safeguard Nova Scotians and Canadians from similar harms going forward.

113. While our client's family is left beyond heartbroken and devastated by the loss of Kristen and Baby Beaton, we urge the Commission to make strong, pointed, practical, and implementable recommendations to ensure the legacy of this Commission and its work honours the victims and those affected by the Mass Casaulty.

ALL OF WHICH IS RESPECTFULLY SUBMITTED



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