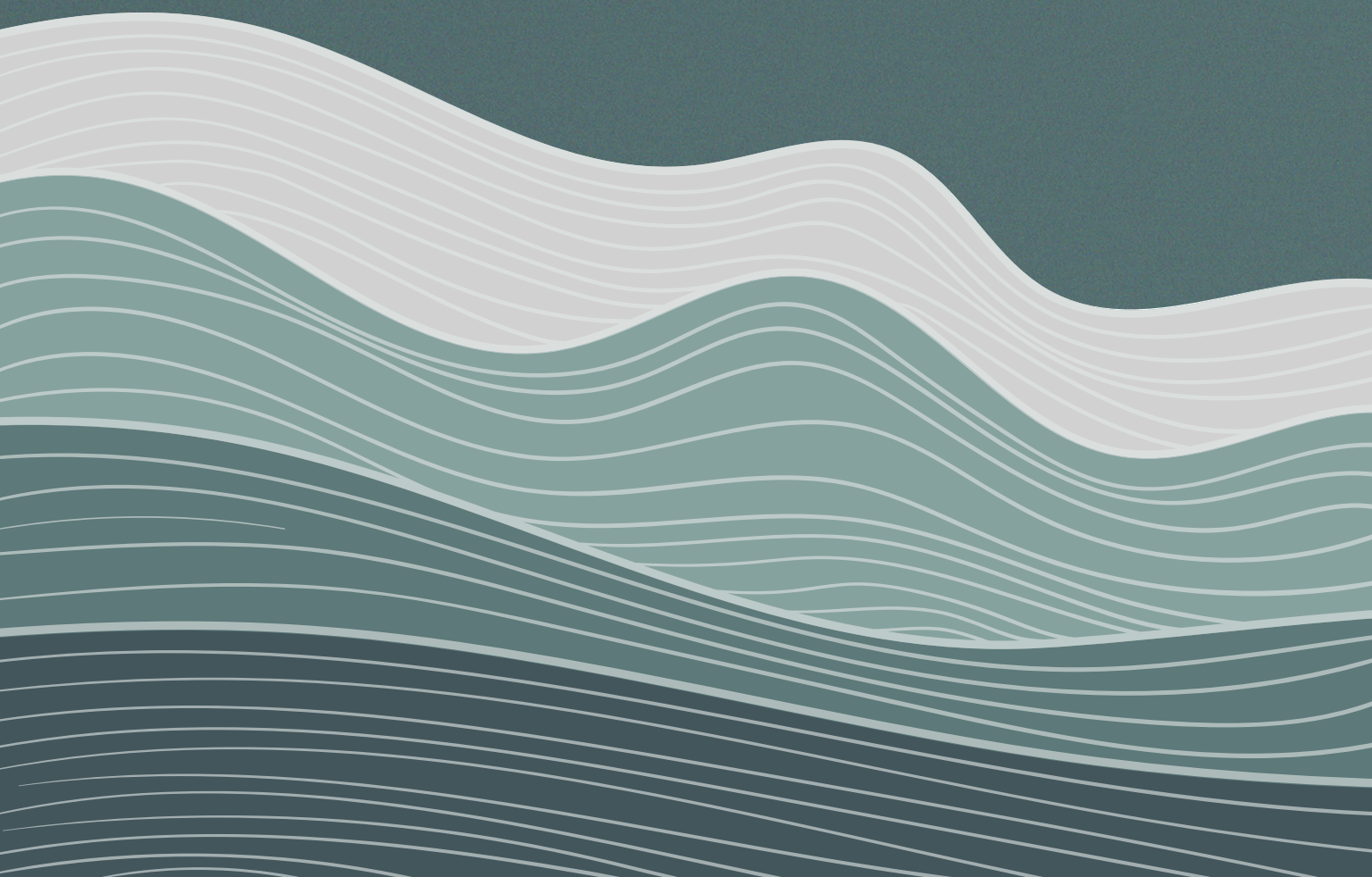
The Joint Federal/Provincial Commission into the April 2020 Nova Scotia Mass Casualty

MASS CASUALTY COMMISSION

Turning the Tide Together

FINAL REPORT OF THE MASS CASUALTY COMMISSION

Volume 5
Policing



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The Joint Federal/Provincial Commission into the April 2020 Nova Scotia Mass Casualty

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FINAL REPORT OF THE MASS CASUALTY COMMISSION

March 2023

Volume 5
Policing

THE JOINT FEDERAL / PROVINCIAL COMMISSION INTO THE APRIL 2020 NOVA SCOTIA MASS CASUALTY

Honourable J. Michael MacDonald
Commissioner, Chair

Leanne J. Fitch (Ret. Police Chief, M.O.M.)
Commissioner

Dr. Kim Stanton
Commissioner

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Volume 5: Policing

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This is one of seven volumes of
Turning the Tide Together: Final Report of the Mass Casualty Commission.

The full report is available in English (https://MassCasualtyCommission.ca) and French (https://commissiondespertesmassives.ca) along with transcripts, exhibits, webcasts, and reports prepared by or for the Commission.

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Navigating This Report

Mental Health and Wellness

Sometimes reading about distressing or emotionally overwhelming information can be challenging. As you read this Report, please make sure to keep mental health and wellness in mind. If you or someone you know is in need of support, consider the resources listed below or check with your local health authority or the Canadian Mental Health Association at cmha.ca to find resources in your area. A list of services is also available on the Commission website MassCasualtyCommission.ca.

- If you are experiencing distress or overwhelming emotions at any time, you can call the **Nova Scotia Provincial Crisis Line 24/7 at 1-888-429-8167**. You do not have to be in a crisis to call, and nothing is too big or too small a reason to reach out. The Nova Scotia Provincial Crisis Service can also provide the contacts for other crisis services that are available if you live outside Nova Scotia.
- If you or someone you know is struggling in any way, you can call **211** or visit 211.ca. 211 offers help 24 hours a day in more than one hundred languages and will be able to connect you directly to the right services for your needs.
- The **Kids Help Phone** is a national helpline that provides confidential support at 1-800-668-6868 or Text CONNECT to 686868.
- Additional supports for across Canada are available at www.wellnesstogether.ca.

Report Structure

Turning the Tide Together, the Final Report of the Mass Casualty Commission, brings together everything we have learned about the April 2020 mass casualty in Nova Scotia as well as our recommendations to help make communities safer.

The Report is divided into seven volumes. Volumes that are longer are divided into parts and chapters focusing on specific topics, while others just contain chapters. Recommendations, main findings, and lessons learned are woven throughout the Report and are also listed in the Executive Summary. Appendices and annexes are also available. All materials relating to the Final Report are available on the Commission website MassCasualtyCommission.ca and through Library and Archives Canada.

Each volume of the Final Report focuses on an area of our mandate:

Volume 1 Context and Purpose

Volume 2 What Happened

Volume 3 Violence

Volume 4 Community

Volume 5 Policing

Volume 6 Implementation – A Shared Responsibility to Act

Volume 7 Process, and Volume 7 Appendices

Annex A: Sample Documents

Annex B: Reports

Annex C: Exhibit List

We hope this Report not only encourages conversations about community safety but also helps people and organizations to move from conversation to collective action. Together we can help to make our communities safer.

We remember

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 McLeod

Lisa McCully

Heather O'Brien

Jolene Oliver, Aaron Tuck, and Emily Tuck

Constable Heidi Stevenson

E. Joanne Thomas and John Zahl

Joey Webber

Introduction to Volume 5

INTRODUCTION TO VOLUME 5

Volume 2, What Happened, sets out a narrative overview of what happened leading up to, during, and in the immediate aftermath of the mass casualty in Nova Scotia on April 18 and 19, 2020. In addition, it contains our first set of main findings with respect to the perpetrator's actions and the responses of individuals and the community, the RCMP, and other police and emergency response agencies.

Volumes 3, 4, and 5 build on these main findings and examine them in light of the causes, circumstances, and context of these events. Our mandate directs us to include 11 specific issues as part of our examination of how and why the mass casualty occurred. We canvassed these specific issues in relation to three broad themes, and each of these themes is the subject of a volume in this Report: Violence (Volume 3), Community (Volume 4), and Policing (Volume 5). These volumes contain our additional findings and conclusions with respect to a range of topics within each theme, and they expand on them by identifying lessons to be learned and recommendations for action.

In Volume 3, Violence, we make factual findings regarding the perpetrator's history of committing violence, including gender-based and intimate partner violence; his acquisition of police paraphernalia, including the replica RCMP cruiser; and his illegal acquisition and possession of firearms. We also outline his interactions with police. We consider these factual findings in the context of what we have learned about the perpetrator, mass casualties, and the prevention of mass casualties.

In Volume 4, Community, we consider community-centred approaches to critical incident response and explain that communities must be at the centre of preparation and planning for critical incidents. We consider this principle, for example, with respect to the design of public warning systems and planning for effective support of individuals who and communities that experience mass violence. (Throughout this volume, we consider the responsibilities of policing agencies toward communities, given that fundamental principle.) In Part C of Volume 4, Community, we

look at how to build a community safety ecosystem that truly incorporates preventive principles. In Parts C and D of this volume, we pick up on this theme to explain the roles of policing agencies within such an ecosystem.

In this volume, we build on the findings and conclusions reached so far by turning to the institutional context of policing. This volume addresses the policing dimensions of the following issues set out in our mandate:

> ...
>
> (iii) interactions with police, including any specific relationship between the perpetrator and the RCMP and between the perpetrator and social services, including mental health services, prior to the event and the outcomes of those interactions,
>
> (iv) police actions, including operational tactics, response, decision-making and supervision,
>
> (v) communications with the public during and after the event, including the appropriate use of the public alerting system established under the Alert Ready program,
>
> (vi) communications between and within the RCMP, municipal police forces, the Canada Border Services Agency, the Criminal Intelligence Service Nova Scotia, the Canadian Firearms Program, and the Alert Ready program,
>
> (vii) police policies, procedures and training in respect of gender-based and intimate partner violence,
>
> (viii) police policies, procedures and training in respect of active shooter incidents,
>
> ...
>
> (x) policies with respect to police responses to reports of the possession of prohibited firearms, including communications between law enforcement agencies, and
>
> (xi) information and support provided to the families of victims, affected citizens, police personnel and the community.

Overview of Volume 5

In Volume 2, What Happened, we provided a comprehensive account of the April 2020 mass casualty and the critical incident response led by the RCMP. We defined a "critical incident" as the term used by emergency services to describe a life-threatening situation in which demand for emergency services outstrips resources, immediate and coordinated responses are necessary even though information about the nature of the incident may be incomplete, and the stakes are very high. We made main findings about many aspects of the critical incident response, particularly relating to decision-making processes, institutional procedures, and the management of information during the mass casualty. We also addressed what happened before and after the mass casualty, and made main findings about red flags and missed opportunities for intervention. Finally, we identified problems that arose in the RCMP's work after the April 2020 mass casualty, including shortcomings in its provision of information and support to those most affected and the public and its failure to conduct an after-action review of its critical incident response. In this volume, we build on that foundation.

In order to evaluate the quality of the critical incident response, we have thoroughly documented the mass casualty of April 18 and 19, 2020, and the response to it. Complex critical incidents are characterized by uncertainty and by their singularity. The individuals who were professionally involved in the critical incident response were placed in that position because they were assigned to work in H Division on that day when the perpetrator set out to murder and cause mayhem. In these circumstances, mistakes and misjudgments on the part of responders and supervisors may be inevitable**. We recognize that these individuals did their best in unprecedented circumstances and that, ultimately, it is the perpetrator who is responsible for his actions. Nonetheless, in order to evaluate the quality of the critical incident response, it is necessary to look carefully at the decisions and actions taken and not taken by some individuals, particularly those who occupied supervisory and leadership roles.**

As the 2012 Gjørv Report on the Norwegian terrorist attacks in Oslo and Utøya helpfully articulates:

> Individuals' actions are influenced by the extent to which the leadership has paved the way for their duties to actually be performed in a satisfactory manner. In society's quest for scapegoats, it is easy to forget that

> imperfect systems can help put individuals in a position to make fatal mistakes.
>
> Meanwhile, it is essential to understand the details. A system is by and large the sum of the individuals who take decisions and perform actions … [A] straightforward, unveiled picture of what went well, and what failed "in the field," is a prerequisite for society to learn lessons from the important leadership-related, strategic and political challenges ensuing from the events. Although it is demanding to be confronted with failures and vulnerabilities, it is necessary in order to learn lessons and ensure a safer society.[1]

We agree with Commissioner Gjørv and, for the reasons she provides, have adopted the same approach in this Report. Our evaluation, first, of the decisions made at key points in the critical incident response and, second, of the RCMP's overall preparedness and processes for critical incident response, is offered in the service of learning the lessons that may be drawn from the mass casualty in order to help keep communities safer in the future. At every step where it was possible for us to do so, we have chosen to learn and not to blame. Our mandate directs us to choose learning, and in Part A of this volume, with that objective, we share details about the critical incident response that offer lessons for future preparation and response.

Accordingly, Part A focuses on effective critical incident response. In Chapter 1, we set out five principles of effective critical incident response that emerge clearly from the extensive research and policy literature we reviewed. These principles are: the importance of critical incident preparedness in the quality of a critical incident response; the uniqueness of every critical incident and the conditions of uncertainty under which decision-makers must act; the necessity of cultivating a culture of interoperability, in which organizations and personnel consistently work respectfully and collaboratively; the importance of recognizing the role played by community members during a critical incident and of communicating effectively with community members; and the value of grasping the opportunity to learn from a critical incident response in order to respond more effectively in the future. These principles guide our discussion of the critical incident response on April 18 and 19, 2020, and of the RCMP's institutional preparedness for effective critical incident response. Also in Chapter 1, we introduce the 2014 report prepared by Ret'd A/Commr. Alphonse MacNeil after a mass casualty incident in Moncton, New Brunswick, in which three RCMP members were killed and two more were injured.

We explain the significance of the MacNeil Report to our work and also identify some limitations to that report.

In Chapter 2, we evaluate the RCMP's policies and preparedness for a large-scale critical incident response in rural Nova Scotia in April 2020. In particular, we consider the extent to which the RCMP had absorbed and implemented the lessons learned and recommendations from the 2014 Moncton mass casualty incident and MacNeil Report. While some good work was done in the immediate aftermath particularly by those who had been directly involved in the Moncton incident, that work was not institutionally sustained and did not produce lasting improvements in preparedness and supervisor training. This chapter also addresses the quality of the RCMP's critical incident decision-making during the April 2020 critical incident response. We analyze the origins and effect of particular problems identified in the main findings in Volume 2, What Happened: uncertainties about command structure, a lack of training for front-line supervisors, the time taken for a trained critical incident commander to take command, the failure to make contingency plans for alternative scenarios, and shortcomings within the command decision-making at various phases of the critical incident response. Throughout this chapter, we document the effects on the overall effectiveness of the RCMP's critical incident response of prioritizing reactive pursuit of the perpetrator over seeking to coordinate the response to ensure that other important tasks such as seeking out and attending to other possible victims and witnesses were also completed.

We found in Volume 2 that the first three 911 calls on the evening of April 18, 2020, supplied crucial information. Portapique community members provided the perpetrator's name, as well as the fact that he was driving a car that looked like an RCMP vehicle although he was not a police officer. By 10:30 pm that night, community members who knew and recognized the perpetrator had given the RCMP a clear and consistent account of his identity and described his replica RCMP cruiser. Chapter 3 of this volume evaluates the RCMP's processes for finding and managing information and explains how this clear and consistent account of the perpetrator's vehicle was lost to the critical incident response. In particular, we identify shortcomings in the RCMP's training, processes, and procedures for managing information during a critical incident response. We share the evidence we heard about best practices for emergency communications centres and information management during a critical incident response, and make recommendations for future practice.

Volume 2, What Happened, also documents other challenges that arose during the critical incident response with respect to information management, internal communication, and coordination. In Chapter 3, we discuss four additional areas that presented particular challenges: tracking member locations, the RCMP's use of mapping technologies, police radio protocols, and the availability of air support.

The RCMP was not the only organization that played a role in the critical incident response of April 18 and 19, 2020. Other police and emergency service agencies were also directly involved in the critical incident response. In Volume 2, we made several main findings related to interagency communications and protocols during the critical incident response of April 18 and 19, 2020. In Chapter 1 of this volume, we explain that interoperability is a key principle of effective critical incident response. In Chapter 3, we share what we learned about how best to cultivate the culture of trust and mutual understanding that is essential to interoperability. We make recommendations to ensure that future critical incident responses are better coordinated across all responding agencies.

In Volume 2, What Happened, we found that the RCMP failed to effectively warn community members of the danger they faced during the April 2020 mass casualty. The RCMP's failure to publicly share accurate and timely information, including information about the perpetrator's disguise and replica RCMP cruiser, deprived community members of the opportunity to evaluate risks to their safety and to take measures to better protect themselves. The evidence we received demonstrates that lives can turn on ensuring accurate and timely public communications during a mass casualty.

Accordingly, in Chapter 4 of this volume, we evaluate the institutional processes and decision-making that led to the RCMP's failure to issue effective public warnings in April 2020. We emphasize that the RCMP was aware of the importance of public communications in critical incident response well before April 2020. The RCMP's failure to have adequate processes and training in place in H Division in April 2020 must be understood against this backdrop. In particular, we consider the history of institutional decision-making that led to a situation in which the command group was unaware of the potential to use Alert Ready to broadcast a public warning about a mass casualty. This chapter also identifies and challenges the persistent operation of myths about how community members will respond to public warnings. We emphasize the police responsibility to issue public communications about how an incident may affect people and the steps they can take to

keep themselves safe. It is unreasonable to expect community members to figure these things out for themselves.

Part B of this volume documents the continuing crisis that afflicted the RCMP in the days, weeks, and months after the mass casualty. In Chapter 5, we consider the efforts made – and those not pursued – to learn from the critical incident response. More than two years after the event, RCMP leadership had done very little to systematically evaluate its critical incident response to the deadliest mass shooting in Canada's history. We discuss the significance of the RCMP's failure to conduct an operational debriefing with those who responded to the April 2020 mass casualty, and evaluate the evidence we heard about the fate of efforts made by some RCMP personnel to obtain an after-action review of the critical incident response. Returning to the five principles of effective critical incident response, we emphasize that the lessons learned from critical incident response are not specific to the responding agencies or to where the incident took place. The public is owed not only the exercise of a review, but the sharing of lessons learned with the broader community to help keep us all safer. Waiting months or years to conduct an after-action review serves no one. Indeed, had the RCMP conducted and published a comprehensive after-action review, some of this Commission's findings and recommendations would likely have been addressed by the organization well before the publication of the Commission's Final Report.

In Chapter 6, we turn to the RCMP's public communications and internal relations after the mass casualty. We set out the policies and procedures that relate to public communications and identify a history of reviews and inquiries making adverse findings about and recommendations for change to the RCMP's approach to public communications. We document evidence that the RCMP provided inaccurate information to the public after the April 2020 mass casualty. We then discuss concerns that arose inside and outside the RCMP about its public communications, as well as concerns within the RCMP about internal briefing practices and a lack of support provided to H Division to assist with public and internal communications after the mass casualty. These concerns set the context for an April 28, 2020, meeting between Commr. Brenda Lucki, members of national headquarters, and senior members of H Division. We describe the circumstances that led to this meeting and evaluate what happened during the meeting. In the final sections of this chapter, we discuss the continuing ramifications of the April 28 meeting for the relationship between H Division and national headquarters, and the persistence of internal conflict within the RCMP over public communications in the months after the mass casualty.

In Chapter 7, we turn to issues management and interagency conflict after the mass casualty. This chapter explains the genesis and role of the issues management team established in H Division, including a disagreement with the Province of Nova Scotia about how this team should be funded. We evaluate the RCMP's approach to two issues that attracted great public interest in the months after the mass casualty: the risks and benefits of using the Alert Ready system for policing, and the 2011 Criminal Intelligence Service Nova Scotia (CISNS) bulletin about the perpetrator. In particular, we consider inter-agency conflict that arose between H Division and municipal police leaders in Nova Scotia about how these issues should be publicly addressed.

In Chapter 8, we turn to the work performed by the Nova Scotia Serious Incident Response Team (SiRT) after the mass casualty and the work performed by the RCMP with respect to the SiRT's investigations. The SiRT investigated two incidents involving RCMP members arising from the April 2020 critical incident response: the Onslow fire hall shooting, and the killing of the perpetrator. In July 2020, the RCMP referred evidence it had received about another Nova Scotia police service to the SiRT, and the SiRT declined to investigate this information. We explain the SiRT's jurisdiction in relation to the RCMP and describe its public reporting responsibilities. We describe communications between the SiRT and the RCMP about the SiRT's investigations. We then turn to the RCMP's July 2020 referral and the SiRT's handling of this referral.

Public trust in the police is integral to the police's capacity to do their work effectively. Public trust is, in turn, affected by public conversations about how well the police do their work, and by how police agencies respond to those public conversations. In Volume 1, Context and Purpose, we documented that the April 2020 mass casualty, and more particularly the RCMP's response to public concern about its response to the mass casualty, created significant public mistrust in the RCMP. However, for many community members, particularly those who have a history of being overpoliced and underprotected by police, trust in the police was already low. Conversations about the RCMP's work in the April 2020 critical incident response played out against a broader conversation about the role and limits of the police in fostering and safeguarding community safety.

In Volume 4, Community, we explained that community safety is best conceived as an ecosystem in which police agencies play an important but limited role, and in which the contributions of other agencies have been underacknowledged and – crucially – underfunded. We suggested that establishing an inclusive vision of community safety and a process for achieving that vision is an essential step for

every Canadian community. In Parts C and D of this volume, we turn to the role of the police within that approach to community safety.

In Part C, we build a framework for improving community safety by making police agencies more democratically accountable, more attentive to evidence about good practice, and better oriented to articulating and serving the common good rather than particular interests. While some of the fundamental features of a policing system that follows these principles are already in place in Canada, much work remains to be done.

In Chapter 9, we consider the question, "What are the police for?" We suggest that establishing clear answers to this question is a precondition to democratic deliberation about the functions the police serve and how they do their work. We adopt, and recommend that Canadian police agencies and governments adopt, eight principles of policing that address the role of police in a democratic and inclusive society. Chapter 9 also explains how the lessons learned (and not learned) by police and government agencies from past reports about policing, and the efforts made (and not made) to implement and sustain this learning, have shaped our work and recommendations.

In Chapter 10, we propose a future for the RCMP. First, we take stock of what we learned about the current state of the RCMP's management culture and operational effectiveness, particularly in its contract policing service. We recommend statutory amendments to the *RCMP Act* to clarify the relationship between the RCMP commissioner and responsible minister and to strengthen the role of the RCMP Management Advisory Board and Civilian Review and Complaints Commission. In each case, these amendments will also promote the public transparency and democratic accountability of these bodies. We then turn to the RCMP's relations with its contract partners. A recurring theme of reviews of the RCMP is the challenge of ensuring that the RCMP's provision of contract policing services is responsive and accountable to the communities it serves. We discuss the role of the contract management committee and the RCMP's failure to address the persistent issue of staff shortages within contract policing. We conclude that the RCMP's tendency not to include contracting partners in its strategic decision-making, documented in past reports, persists, and that the RCMP has failed to adopt a strategic or coordinated approach to contract policing policies and core policing functions.

We then turn to the important topic of rural policing. The RCMP's career model undervalues rural general duty policing, regarding that work as the first step in a

career ladder that will bring members to other policing functions and locations. This approach creates a disconnect between RCMP members and the communities they serve, and it fails to recognize and foster the distinctive skillset that is required for effective rural policing. We identify that maintaining the unique responsibilities of police under the rule of law necessitates that adequate policing services be provided in rural and remote communities.

Throughout this Report, we emphasize that effective police agencies are learning institutions: capable of recognizing and responding to the changing expectations of the communities of which they are part, and capable of learning from their past actions in order to do better in the future. In the next section of Chapter 10, we explain how police recruitment, education, and research contribute to the effectiveness of police services, and we evaluate the RCMP's approach to these functions.

The last section of Chapter 10 discusses the RCMP's management culture. By management, we refer to commissioned officers, which in the RCMP means those sworn members who hold the rank of inspector, superintendent, chief superintendent, assistant commissioner, deputy commissioner, and commissioner. We also include civilian employees who hold equivalent ranks or leadership positions. We are particularly focused on management culture because, if the RCMP is to make the significant changes we call for in this Report, the work of leading these changes and engaging members in them will be led by commissioned officers and their civilian equivalents. Indeed, if the RCMP's management does not share a commitment to making these changes – or worse, if some members of management actively work to undermine efforts to reform the RCMP – these efforts will likely fail.

In Chapter 11, we turn to the future of policing in Nova Scotia. We provide a brief history of policing in Nova Scotia and a description of the present structure of policing services in the province. This chapter also describes some of the key reforms that have been made to the police in Nova Scotia since colonization. We then set out six recommendations for changes that should promptly be made to Nova Scotia policing. These changes can and should be implemented while broader conversations about community safety are unfolding. We call for a structured community-wide process to discuss and decide the future structure of policing services in Nova Scotia.

Part D of this volume considers the everyday practices of policing that contribute to the overall effectiveness and legitimacy of the police. In Chapter 12, we explain that low-visibility decision-making is a defining feature of police work and a

particular characteristic of the work performed by front-line police officers. The discretion exercised daily by police officers in their interactions with community members is best understood as a permission that is extended by society to individual police officers to use "their considered judgment in certain ways in certain situations." Legal and constitutional principles, including *Charter* rights and freedoms, set limits to police discretion. Nonetheless, most exercises of police discretion will never come to any form of official attention or review. Every day, front-line police make decisions about matters such as what questions to ask a complainant or person of interest, what follow-up needs to be done about a particular matter, how to categorize a complaint that does not lead to further investigation or charges, what to write in their notebooks, when to make a more formal record of their activities, which streets to walk or drive along, when to stop and look more closely at something they have observed, and when to initiate an interaction with someone they have observed. These decisions have a significant impact on what crime and social problems come to broader official attention and how effectively social problems are countered. They also affect community trust in the police.

The police power to shape the official record by the manner in which front-line officers exercise discretion is not merely a theoretical concern. In our process, we heard about police failures to hear and respond effectively to community members who expressed fear of the perpetrator or sought to report his violence. These accounts were echoed in other incidents that were well known to, and widely discussed among, community members and experts who contributed to our work. Two other examples from rural Nova Scotia arose repeatedly in these conversations: the RCMP response to complaints made in 2017 by Colchester County resident Susan (Susie) Butlin about her neighbour Ernie Duggan before Mr. Duggan killed Ms. Butlin; and the RCMP's treatment in 2007–8 of Digby County resident Nicole Doucet (also known as Nicole Ryan), who was subjected to violence including coercive control by her husband, Michael Ryan. We introduce these examples in Chapter 12 and return to them throughout Part D of this volume, along with other evidence we heard about how police exercise their discretion when gender-based and intimate partner violence are reported.

The problems that we document throughout this Report are long-standing and far from simple. However, in Chapter 13, we suggest that everyday policing practices can be improved by implementing a coordinated set of fundamental strategies, each of which is designed to improve how front-line police exercise their decision-making authority in low-visibility situations. These five strategies address the selection of police students and police recruits, police education, note taking

and record keeping, front-line supervision and feedback, and community-engaged policing.

Throughout Volumes 3, 4, and 5 of this Report, we document the evidence we heard and make findings and recommendations that point the way toward a paradigm shift in our community-wide approaches to policing and to gender-based, intimate partner, and family violence. The focus of the whole community safety ecosystem should be: How do we prevent further violence? Within an ecosystem of community safety, police have a limited but crucial role to play.

Chapter 14 of this volume builds on recommendations made in Volumes 3 and 4 to consider the relationship between everyday practices of policing, equality, and securing community safety. We identify the need to shift police officers' understanding of their role to acknowledge the primacy of securing the safety of those who experience violence. We also identify the central role played by misogyny within the police failings that are documented throughout this Report. These problems are not limited to the RCMP: they are also present in other Canadian police services. Indeed, as we documented in Volumes 3 and 4, misogyny is not by any means limited to policing. Nonetheless, the operation of misogyny within policing is particularly harmful to women's equality, and therefore to all of us, and can undermine achievements in law reform and efforts to modernize policy. Police bring to their work a set of largely unexamined assumptions about their role as police, about what real violence and real victims look like, and about what kinds of problems they can help to solve. In Chapter 14, we suggest that countering misogyny, racism, homophobia, and other attitudes that undermine universal human dignity must be placed at the centre of everyday policing practices across Canada.

Part A:
The Critical Incident Response

Introduction

INTRODUCTION

Jamie Blair's 911 phone call, placed at 10:01 pm from her home on Orchard Beach Drive in Portapique, was the first police and emergency services notification of what was unfolding in Portapique on the evening of April 18, 2020. Her call ended when the perpetrator murdered her as she was conveying information to the Operational Communications Centre while protecting her children from him. The four general duty RCMP members from the Bible Hill detachment who were working that night were quickly dispatched toward Portapique, and so began a critical incident response that lasted until approximately 11:30 am the following day, April 19. The immediate response to the critical incident ended when members were told to stand down from their active search for the perpetrator. At this time, the RCMP confirmed to responding members that the RCMP had the perpetrator in custody, and soon after, that he was dead.

Over the 13½ hours of the active critical incident response, many RCMP members were directly engaged in seeking to find the perpetrator and stop his rampage. (Even the RCMP is uncertain of exactly how many were involved.) The initial response was coordinated by the RCMP risk manager, S/Sgt. Brian Rehill, who was stationed at the Operational Communications Centre (OCC) in Truro, with support from other non-commissioned officers who gathered at Bible Hill detachment. At approximately 1:20 am on April 19, the critical incident commander, S/Sgt. Jeffrey (Jeff) West, took control of the critical incident response, having established a command post in the fire hall at Great Village, approximately 10 kilometres east of Portapique.

In Chapter 1, we set out five principles of effective critical incident response. These principles guide our discussion, over the rest of Part A, of the critical incident response on April 18 and 19, 2020. In Chapter 2, we discuss the command structure, the RCMP's preparedness for a critical incident response of this scale, and the complexities of coordinating this critical incident response. In Chapter 3, we evaluate the RCMP's processes for finding and managing information during the response.

Other police agencies were also directly involved in the critical incident response. For example, the Halifax Regional Police was dispatched to the perpetrator's Dartmouth residence, obtained statements and secured potential targets, and established containment on the major routes into the Dartmouth area. Some of its officers were stationed very close to the Enfield Big Stop when the perpetrator was killed and attended the scene in the immediate aftermath of this incident. The Truro Police Service was tasked with protecting the Colchester East Hants Health Centre and, at 10:37 am on April 19, asked by an RCMP OCC dispatcher to "lock down" the town of Truro.[1] Resources from other provinces were also engaged: for example, the RCMP's New Brunswick Emergency Response Team was called in, as were some New Brunswick–based RCMP Emergency Medical Response Team members.

Other emergency services were also engaged in a range of ways. For example, Emergency Health Services paramedics cared for injured witnesses and transported them to hospital. Volunteer fire services provided space for both the command post and a comfort centre and prepared to respond to fires set by the perpetrator. The emergency management coordinator for the Colchester Regional Emergency Management Organization, David (Dave) Westlake, established and staffed the comfort centre at the Onslow Belmont Fire Brigade hall, which was intended to provide a place for those evacuated from Portapique to gather safely and receive support. The Nova Scotia Emergency Management Office prepared to assist with public communications. In some instances, representatives of municipal police services and other emergency services offered expertise or assistance that was not accepted by the RCMP. In other instances, as with air support, when the RCMP sought support from emergency service agencies, it was not forthcoming or was not available at the time it would have been most helpful. We discuss questions about interoperability, or how well agencies work with one another during a critical incident response, in Chapters 1 and 3.

At every stage of the critical incident response, community members played a crucial role. Most poignantly, they included Jamie Blair, Lisa McCully, Tom Bagley, Joseph (Joey) Webber, Andrew MacDonald, and others who died or were injured while responding directly to the chaos caused by the perpetrator. They also included, for example, community members who called 911 to offer information about the perpetrator, his disguise, and his whereabouts, and those who shared information directly with RCMP members as they were engaged in the critical incident response. In Chapter 2 of Volume 2, What Happened, we found that community members played an indispensable role in the critical incident response, and

that this role was not adequately acknowledged by the RCMP. These community members showed courage and selflessness in their efforts to protect others.

The mass casualty of April 2020 is not unique in this respect – reviews of critical incidents in other jurisdictions also demonstrate that in extraordinary circumstances, ordinary community members show great dedication to helping first responders and others in their communities. This recognition that civilians are the true first responders and the bearers of crucial information should be factored into critical incident planning and preparation. The contributions made by community members in these circumstances should be acknowledged and respected by professional responders including police. In Chapter 3 of this volume, we identify shortcomings in the RCMP's processes and procedures for managing information that is received from community members during a critical incident response.

The pattern of this critical incident response clearly shows the centrality of community members and the importance of responders attending carefully to the information community members share (or may be able to share) with emergency services. It also shows the extent to which a critical incident of this scale requires coordination across police agencies and other emergency services, including communications centres, emergency healthcare providers, fire services, and emergency management offices. This kind of coordination depends on pre-existing, trusting working relationships, careful planning and preparation, and mutual understanding of roles and responsibilities. For this reason, Chapter 3 also considers the interactions between police and community members and between police and other agencies.

Finally, in Chapter 4, we turn from the RCMP's internal processes for managing and sharing information to its approaches to warning community members and safeguarding public safety during the mass casualty. We address two aspects of this process: The RCMP's use of Twitter and Facebook as the primary platforms for issuing public information during the mass casualty, and the failure to issue a public warning using the Alert Ready system.

CHAPTER 1

Five Principles of Effective Critical Incident Response

CHAPTER 1 Five Principles of Effective Critical Incident Response

A considerable body of research and policy studies now exists about critical incident preparedness and best practices for responding to mass casualties including active shooter incidents. Much of this research has been generated in response to major incidents and trends in other jurisdictions, including the United States, the United Kingdom, Norway, New Zealand, and Australia. The Commission adopted a variety of strategies to obtain an understanding of the research and policy advice in this area, including conducting an environmental scan of prior recommendations emerging from past Canadian reports and an international scan of recommendations made in response to mass casualties; commissioning expert reports; searching for relevant academic literature; and assembling roundtables of Canadian and international experts.

We found relatively little Canadian research or policy analysis of critical incident preparedness and best practices for critical incident response. This gap does not reflect a lack of Canadian experience with mass casualties. As we explained in Volume 3, Violence, the expert reports prepared for the Commission by Dr. Blake Brown[1] and by Dr. David Hofmann, Willa Greythorn, and Dr. Lorne Dawson[2] list many examples of Canadian mass casualties, including many that did not precipitate inquiries or other public reviews or academic evaluation. In Part C of this volume, we discuss the relative lack of empirical research into policing in Canada. In this chapter, we discuss an important Canadian report on critical incident response: the 2014 report prepared by retired RCMP A/Commr. Alphonse MacNeil. This report evaluated the RCMP's response to a mass casualty in Moncton, New Brunswick, in which three RCMP officers were killed and two were wounded by shooting.

Looking beyond Canada's borders, we found a wealth of research and policy documents about police and emergency services preparedness for critical incidents, and best practices in critical incident response. Looking to other jurisdictions for this knowledge is useful for at least two reasons. First, adopting the principles of effective critical incident preparedness and response that are documented in

policy reports and other literature provides a benchmark for good practice that can mitigate the risks of hindsight bias that we identify in Volume 1 of this Report, Context and Purpose. For our purposes, **hindsight bias means using information we know now to evaluate decisions made and actions taken at a time when the facts and outcomes were much more uncertain, and the actors did not have the opportunity for extended reflection or analysis**. International reviews of critical incident responses provide an expert and independent reference point for best practices, against which we can fairly assess the quality of the critical incident response in Nova Scotia on April 18 and 19, 2020. Second, we found many constructive ideas emerging from policy reports and research. These ideas helped us and the Participants to formulate recommendations for future practice in Canada.

A number of strong and consistent principles for effective critical incident response emerge from the literature on critical incident preparedness and best practices. Each of these principles is well established within the literature. The international incident reviews and research literature show that when these principles are not followed, critical incident responses suffer. Ineffective critical incident responses can result in more casualties and cause damage to community trust in police and other emergency services.

The first principle universally emphasized in policy reports and academic research is the indispensable role played by critical incident preparedness in the quality of a critical incident response. Organizations that have anticipated that a critical incident may arise, have trained their personnel, and have established clear roles and responsibilities for a critical incident response will generally respond more effectively. Second, many studies identify that the uniqueness of every critical incident and the conditions of uncertainty under which decision-makers must act present a universal challenge to critical incident responses. This characteristic of critical incidents affects how organizations and individuals can best train and prepare for critical incident response, and some research offers strategies for addressing this challenge. Third, because a large-scale critical incident response draws in many emergency responders across multiple organizations, it is important for leaders of emergency response organizations to actively cultivate a culture of interoperability, in which organizations and personnel consistently work respectfully and collaboratively. This culture must be consciously fostered well before a critical incident takes place. Fourth, reports and research emphasize the role played by community members in critical incident response and the importance of providing clear, timely, and accurate public communications to support community safety during a critical incident. Finally, reports, research, and experience

demonstrate that taking the opportunity to study critical incident response in a timely way after an incident has happened – and implementing change on the basis of lessons learned from those studies – are key strategies by which organizations improve the quality of their critical incident responses and help save lives in the future.

The RCMP's 2014 MacNeil Report

A report prepared by Ret'd. RCMP A/Commr. Alphonse MacNeil about a 2014 mass casualty in Moncton, New Brunswick, supplies an important exception to the general lack of Canadian work on this topic. On June 4, 2014, a perpetrator shot and killed three RCMP members and injured two more in an incident that lasted approximately 29 hours and entailed a multi-agency response from the time when the first 911 call was received until the perpetrator was arrested. On June 30, 2014, RCMP Commissioner Bob Paulson asked Ret'd. A/Commr. MacNeil to conduct an "independent review of the circumstances surrounding the shootings."[3] Commissioner Paulson identified 13 areas that should be considered by Ret'd. A/Commr. MacNeil, including topics such as tactics and response to 911 calls, decision-making and risk assessment, supervision, equipment and weapons, member training, and operational communications. There are therefore considerable areas of overlap between the questions considered by Ret'd. A/Commr. MacNeil and those that we have been asked to examine with respect to the mass casualty of April 18 and 19, 2020.

Ret'd. A/Commr. MacNeil delivered his report to the RCMP on December 1, 2014. He made 64 recommendations on matters including training for front-line supervisors, public communications during critical incidents, the use of hard body armour during critical incidents, critical incident response training for RCMP members, and methods of tracking RCMP members when they are away from their police vehicles. In an affidavit dated August 11, 2022, Insp. Pharanae Croisetiere provided information to the Commission about the implementation of each of these recommendations. Insp. Croisetiere is the officer in charge of operational policy and compliance in the Criminal Operations Branch of the RCMP. The RCMP also provided a chart setting out the implementation status for each recommendation as of January 2020. The Attorney General of Canada submitted to the Commission that 62 of the 64 recommendations have been implemented. Throughout this volume, we

refer to many of the recommendations made in the MacNeil Report and evaluate the quality of the RCMP's implementation of these recommendations.

The RCMP characterizes the MacNeil Report as an independent review of its actions in Moncton (and indeed the report is titled *Independent Review Moncton Shooting – June 4, 2014*). The MacNeil Report provides a useful review of what went well and where problems arose in the critical incident response in Moncton in 2014. As we explain further in chapter 5 of this volume, we recommend that the RCMP and other Canadian police services ask an uninvolved but knowledgeable person to conduct a rigorous after-action review following every critical incident response to a mass casualty. The results of this review should be made public, as the MacNeil Report was.

However, we do not agree that the MacNeil Report is properly described as an independent review of the RCMP's critical incident response in Moncton.

In her interview with the Commission and in her testimony, RCMP employee Ms. Lia Scanlan was forthright about her role in the Moncton response and about the process by which the MacNeil Report was written. In April 2020, Ms. Scanlan was the director of the Strategic Communications Unit for the RCMP's H Division (Nova Scotia). The Strategic Communications Unit is responsible for public communications and media liaison. Ms. Scanlan was also actively involved in the public communications in Moncton in 2014. In an interview with the Commission, she explained:

> [During the Moncton incident] I went into the Codiac detachment and took over the comms role there. It was to relieve their Director … so he could get some sleep … I took over the external communications. So, when I say I took over there, what I mean is so that's all of the … the tweeting and all of the, you know, managing what we're saying publicly, but most importantly, what we're saying to the public, because the gunman was at large.[4]

Ms. Scanlan explained that Ret'd. A/Commr. MacNeil had been the commanding officer of H Division before his retirement in February 2014. In her role as senior advisor in strategic communications at H Division, Ms. Scanlan had been the primary liaison with Ret'd. A/Commr. MacNeil. When he took on the work of reviewing the Moncton response, Ret'd. A/Commr. MacNeil recruited Ms. Scanlan to act as strategic advisor and writer. Ms. Scanlan explained that she had co-authored the

MacNeil Report and that she had a considerable role in preparing the communications and media portion of the report, in particular.

The MacNeil Report is a useful document, and its value is enhanced by Ret'd. A/Commr. MacNeil's knowledge of the RCMP and of policing more generally. That being said, even without Ms. Scanlan's evidence, we would be cautious about the independence of a report produced by an officer who had served an organization for 38 years but had been retired for approximately four months at the time of being engaged to provide a review of the organization's activities.[5] However, in light of Ms. Scanlan's testimony, we find that the relationship between the report writers and those involved in the critical incident response in Moncton in June 2014 was not arm's length. Accordingly, for our purposes, the report is not properly described as an independent review.

The MacNeil Report provides insights into the RCMP's best practices and the considerations that it finds relevant to appraising the quality of a critical incident response. It also provides a historical record of recommendations made by a knowledgeable RCMP insider. We have relied on the MacNeil Report for these purposes. Throughout this volume, we have also drawn on evidence provided by the RCMP about its implementation of Ret'd. A/Commr. MacNeil's recommendations.

Principles of Effective Critical Incident Response

Five principles emerge strongly and consistently from the literature on effective critical incident response, including reviews of critical incident responses, policy papers, and academic research.

Principle 1: Critical Incident Preparedness

The first of these principles is a universal emphasis on the essential role of critical incident preparedness in the quality of a critical incident response. Dr. Bjørn Ivar Kruke is an associate professor in risk management and societal safety at the

University of Stavanger, Norway. He has considerable experience in the evaluation of police and emergency services responses to mass casualties, having served as an expert-report writer for the Gjørv Commission into the July 22, 2011, mass casualty in Norway, and as co-author of an evaluation of the critical incident response to a mass casualty incident in Kongsberg, Norway, on October 13, 2021. The July 22, 2011, mass casualty in Norway was the deadliest civilian mass shooting in history, killing 77 people and injuring many more across two locations. The Norwegian Parliament commissioned Alexandra Bech Gjørv to lead a fact-finding commission and make recommendations. The Gjørv Report was delivered to the Norwegian prime minister in 2012. The 2021 mass casualty in Kongsberg was an incident in which five people were killed and others injured in that Norwegian town by a perpetrator armed with a bow and arrows and a knife. In June 2022, Dr. Kruke and his co-authors submitted their evaluation of the work of police and security forces in this instance to the Norwegian Police Directorate and Police Security Service. Both the Gjørv Report and the Kongsberg Report evaluate the quality of police and emergency services response to critical incidents, identify lessons learned from their reviews, and make recommendations for the future.

Dr. Kruke explained in an expert report prepared for the Commission that the study of critical incident response is "often event driven" in the sense that "a high-profile or notable event will often promote a flurry of research and policy activity."[6] However, Dr. Kruke drew on an extensive literature to suggest that **it is most fruitful to understand a critical incident as the "acute crisis" within an extended process that moves from prevention and preparedness into the acute crisis and from there, into a post-crisis mode of learning and recovery. Ideally, the process of learning from a crisis should lead "to more robust capacity to deal with subsequent crises."**[7] Dr. Kruke emphasizes that "the swift and robust mobilization and deployment of response personnel" depends "most of all" on "preparedness activities in the pre-crisis phase."[8] In short, "the quality of these preparedness activities … [is] revealed in the quality of the response, i.e. the ability to reduce the consequences of the event."[9]

Principle 2: Adaptability to Making Decisions Under Conditions of Uncertainty

A second strong principle that emerges from the reports and literature is that every critical incident is unique, and therefore that training and preparation

must prepare first responders to make decisions and act in conditions of considerable uncertainty. This dimension of the challenges of critical incident response is well described in an independent report prepared in 2017 by the US-based Police Foundation (now the National Policing Institute), following a 2016 mass casualty in the Pulse nightclub in Orlando, Florida. In this incident, 49 people were killed and 53 were injured by a perpetrator who used two semi-automatic weapons (a rifle and a handgun) to fire on patrons of a nightclub. The Pulse nightclub was a popular venue for the Two-Spirit, lesbian, gay, bisexual, transgender, queer, intersex and additional sexually and gender diverse (2SLGBTQI+) community, and the majority of victims were Hispanic. When police entered the nightclub, they encountered horrifying scenes of dead and injured patrons while the perpetrator barricaded himself with hostages in a washroom. Emergency responders evacuated injured patrons, searched for explosives (the perpetrator claimed to have planted explosives within and around the nightclub), assisted hostages to escape, and sought to stop the perpetrator from committing further acts of violence. The authors of the independent review of the police response in Orlando reported that:

> **Many of the law enforcement, fire, emergency medical services, and medical personnel interviewed by the assessment team stressed that the "mindset [of first responders] is key" to their ability to operate in overwhelming and unimaginable environments. They repeated over and over again that command personnel and officers needed to train and practice decision-making and tactics in environments that simulate, as much as possible, the realities of uncertain, devastating, and overwhelming operating environments.**[10]

Although the specific facts differ, the Orlando responders' description of "chaos, devastation, and horrific circumstances" parallel those offered by RCMP members who responded to the mass casualty in Nova Scotia in April 2020.

We commissioned Dr. Laurence Alison and Dr. Neil Shortland to prepare an expert report on the challenges of managing critical incident responses to unique and high-consequence events. Dr. Alison is chair of forensic and investigative psychology at the University of Liverpool in England. Dr. Shortland is director of the Center for Terrorism and Security Studies at the University of Massachusetts, Lowell, in the United States. These two academics use experimental and empirical methods to study critical incident decision-making and the mistakes that decision-makers

tend to make in the demanding environment of a critical incident. Dr. Alison and Dr. Shortland explain:

> **In an ideal world, decision-makers would either have rules or protocols for every eventuality and/or always be able to draw upon enough previous similar experiences to be considered "experts." However, critical incidents are rare and often unique. It is therefore difficult if not impossible to perfectly match any protocol to a singular critical incident. … Instead, they must learn and practice innovative, creative, and adaptive strategies[.]**[11]

Dr. Alison and Dr. Shortland identify that the uncertainty and high stakes of critical incident decision-making can produce a phenomenon that they term "decision inertia," in which a decision-maker feels unable "to commit to a course of action in time, or at all."[12] When decision inertia sets in, "actions fail to occur, even when it seems clear that an action is required."[13] These researchers have found that there are three ways in which decision-makers fail to act.

Three forms of decision inertia

1. **Decision avoidance** arises when a person avoids making a choice or decision.
2. **Redundant deliberation** happens when a decision-maker defers a decision even though additional helpful information is unlikely to be yielded.
3. **Implementation failure** happens when the decision-maker or others within the organization fail to follow through on a decision that has been made.[14]

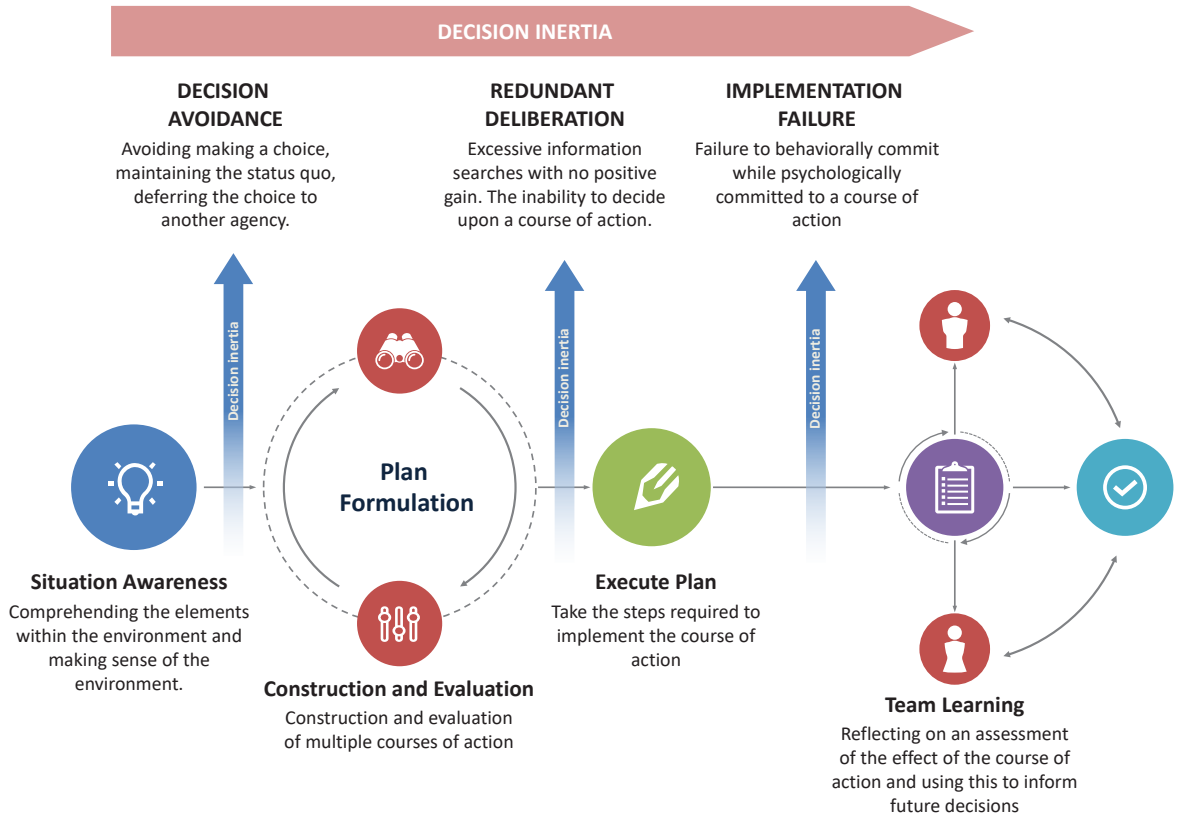
Dr. Alison and Dr. Shortland therefore advocate that **police agencies train critical incident decision-makers in a range of strategies that will help them to be prepared for the chaotic and uncertain conditions that pertain during a mass casualty.** We return to these strategies in Chapter 2.

In his expert report, Dr. Kruke similarly identified adaptability under conditions of uncertainty as a core determinant of the effectiveness of an agency's response to a critical incident. Therefore, he explains, **a critical incident response draws on two key determinants:**

1. **implementation of planned and trained structures from the preparedness activities in the pre-crisis phase; and**
2. **adaptation of the response to the situation at hand.**

Thus, crisis management in the acute phase will be a test of the quality and relevance of our contingency planning and the planned, trained structures of the crisis response – but it will rely heavily on critical decision-making under a high degree of uncertainty. Even with proper preparedness planning and training in the pre-crisis phase, there will always be a need for adaptation to the specifics of a particular crisis.[15]

Three Different Points of Decision Inertia Within the CIDM Process



Source | Laurence Alison & Neil Shortland, "Critical Incident Decision Making: Challenges of Managing Unique and High-Consequence Events." Expert report prepared for the Commission, 18.

Principle 3: Effective Interoperability of Emergency Response Agencies

A third strong principle that is set out in the critical incident literature is the indispensable role of interoperability: "[L]large-scale crises require police services, fire and rescue, and emergency medical services to work effectively together, along with municipal, provincial / territorial, and federal agencies."[16]

Interoperability

In this context, interoperability means the capacity of different emergency response agencies to work together during a critical incident.

In his 2015 paper "Critical Incident Response: The Case of the Population Contribution," Dr. Kruke explains:

> **No sector of society can handle major accidents, crisis or terrorist attacks by themselves. Societal safety and security in times of crisis is therefore based on extensive cooperation and collaboration among many public and private actors.**[17]

During a critical incident, interoperability is a fundamental attribute of an effective response. However, interoperability is a valuable aspiration even in more normal times. As Commissioner Gjørv explained, "[B]oth civil protection and emergency preparedness require that the country's aggregate resources be utilized efficiently. This calls for coordination and interaction."[18] Almost half of the Gjørv Report's recommendations related to problems of coordination, interoperability, and mutual aid.

In 2013, the UK Cabinet Office commissioned a review of "persistent lessons" about interoperability from emergencies and major incidents in the United Kingdom.[19] Dr. Kevin Pollock evaluated 32 reports relevant to interoperability during emergencies and major incidents such as mass casualties, natural disasters, and infrastructure failures. He identified nine interrelated "common causes of failure" in interoperability and four strategic issues that help to ensure success.

Nine common causes of failure in interoperability and four strategic issues that help to ensure success

Nine common causes of failure:

1. Poor working practices and organizational planning
2. Inadequate training
3. Ineffective communication
4. No system to ensure that lessons were learned and staff taught
5. Lack of leadership
6. Absence of no-blame culture
7. Failure to learn lessons
8. No monitoring / audit mechanism
9. Previous lessons / reports not acted upon

Four strategic issues that help to ensure success:

1. Doctrine – provision of clear and easily understood guidance that ensures everyone is aware of their own and others roles and responsibilities.
2. Operational communications – the need for a common system used by all stakeholders with the capacity to deal with surges of activity associated with major incidents.
3. Situational awareness – the ability to quickly access and share information between stakeholders.
4. Training and exercising – the need for continuous development of stakeholders to ensure sufficient capacity to cope with a prolonged event.[20]

Dr. Pollock concluded on the basis of his review that the **"consistency with which the same or similar issues have been raised by each of the inquiries … suggests that lessons identified from the events are not being learned to the extent that there is sufficient change in both policy and practice to prevent their repetition."**[21] He suggested **that the key to lasting improvements in interoperability was to foster "a change in organisational culture and personal practices."**[22] In a 2015 paper, co-authored with Dr. Eve Coles, Dr. Pollock explained that successful interagency collaborations "are ideally characterized by reciprocity, representation, equality, participatory decision making, and collaborative leadership."[23]

We commissioned Dr. Curt Taylor Griffiths to prepare an expert report on interoperability and interagency collaboration in Canada.[24] Dr. Griffiths is a professor of criminology at Simon Fraser University whose work focuses on policing and the criminal legal system in Canada. His report characterizes interoperability as a persistent challenge for Canadian public safety agencies. Dr. Griffiths identifies **"the presence or lack of trust" between agencies, and between individual actors, as a key determinant of effective interoperability, concluding that "[i]n short, having an action plan or strategic plan is in itself not sufficient to produce collaboration."**[25] **Dr. Griffiths also identifies the particular organizational culture of individual police organizations as a factor that can impede or enhance interoperability among police services**, citing *Forsaken: The Report of the Missing Women Commission of Inquiry* in British Columbia (2012) as an example of a Canadian report that found that

> [c]ultural barriers between individual police services, as well as between police services and other emergency services, … [can] hinder collaboration, interoperability, and the effective response to threats to community safety and security.[26]

Technological solutions to facilitate communication and information-sharing are inadequate strategies to ensuring interoperability. Culture and trust are essential, and agencies must focus on building trust as a prerequisite to responding collaboratively and in a coordinated fashion to complex critical incidents. Conversely, the common tendency to allow ego or institutional territorialism to prevail over working together with humility and mutual respect will hobble strategies and technologies to promote interoperability.

Principle 4: Recognizing the Role of Community Members

A fourth principle arises from the role played by community members during critical incident responses, and the correlate importance of providing clear, timely, and accurate public communications during a critical incident. Dr. Kruke observes that "[m]embers of the public are often the first to be confronted by a perpetrator of mass violence."[27] He goes on to describe the notions that community members

panic during critical incidents or that they are helpless in the face of such an incident as "common myths."[28] Rather,

> **those civilians who are physically proximate to the event and directly affected are the first to respond, they form "the first shift," and these civilians often engage immediately in life-preserving activities, including saving themselves and protecting others. They are also the ones who call the emergency numbers to inform the professional response organizations, and they can convey relevant information.**[29]

Examples of community members providing assistance to police and other civilians during critical incidents, even at the expense of placing themselves in greater danger, abound. Commissioner Gjørv specifically recognized the contributions of volunteers and community members to the critical incident response in Norway on July 22, 2011:

> Rarely has the value of voluntary involvement and individuals' initiatives been demonstrated more clearly than in the moments after the explosion at the Government Complex and on, and on the banks of, the Tyri Fjord on 22 July. Random passers-by, camping tourists and the residents of Utøya Island were absolutely crucial to one of the most extensive rescue operations ever staged in Norway that afternoon. Ordinary people stepped up and made decisions to act. Their efforts were absolutely crucial for the police operation. Without the efforts of the volunteers that day, more lives would have been lost, and the scope of the devastation would have been even greater.[30]

In short, ordinary people do their best to help themselves and to assist others, especially in the initial phase of a critical incident. The myths that people panic or are helpless in a crisis are harmful because they "guide the way we approach crisis preparedness planning and training, but may also guide professional crisis managers arriving on the scene."[31]

The correlate to the principle that community members can be counted on to assist critical incident responses is that the public must receive clear, timely, and accurate information, including information that will help them to protect themselves and others during a mass casualty. This principle has become even more important in an era in which news of a critical incident spreads quickly from crime

scenes to a large proportion of the population through social media, cellphones, and other digital technologies.

In this context, as elsewhere, preparation is key to effective public communications. This is true in two senses. First, agencies should have plans and well-understood procedures for emergency public communications in place before critical incidents ever arise. The independent review of the Pulse nightclub incident praised the Orlando municipal approach in this regard:

> One of the hallmarks of Orlando's response to the Pulse nightclub attack was the citywide structured, coordinated, and disciplined handling of media and public relations. Prior to this incident, city officials conducted annual emergency management tabletop exercises in which communications was a key function …
>
> [T]he city established a process for communicating about different types of events, including which entity would take the lead to avoid some of the initial confusing and contradictory social media messaging that occurred during similar responses, including the Boston Marathon bombings.[32]

In Orlando, emergency response agencies and elected officials worked closely together to ensure that information was shared with the public in a timely and accurate fashion both during and after the critical incident. They ensured that media and the public were pointed toward authoritative sources of information, and they acted quickly to correct misinformation on social media. The agencies involved in the Orlando response also ensured that local media and local communities who were most affected by the mass casualty (including the 2SLGBTQI+ community and the Hispanic community) received dedicated attention and care. For example, Orlando Police Department "command staff reached out to the Hispanic community daily to make sure all their needs were met and continue[d] to do so" at the time the independent review was prepared.[33] Even before the mass casualty, an Orlando police representative visited a 2SLGBTQI+ community group weekly. These pre-existing relationships became even more important after the mass casualty occurred.

The second sense in which preparation is key to effective public communications relates to **the need for emergency services to provide public education before a critical incident occurs**. The Commission received evidence from Michael Hallowes, who is a former detective chief superintendent of the Metropolitan Police

Service in London, England, and the former emergency services commissioner for the State of Victoria in Australia. Mr. Hallowes has participated in the design and implementation of public emergency warning systems in numerous jurisdictions. In his testimony, he emphasized the importance of providing the public with information about emergency communications before a public warning is issued:

> [T]he public's ability to understand the urgency of the message as a recipient and to know what they need to do in response to stay safe and not place any additional burden on the emergency services, is part of the most critical element to success …
>
> "**Warnings are for the informed." Meaning, quite profoundly, that if you have not educated the public, it's just more noise in the background. Educating the public to wake up and realise we have a very serious incident that affects your life, and you will have been prepared through a solid community preparedness and education program, increases the chances of the public doing the right thing.**[34]

Mr. Hallowes explained that an important aspect of community preparedness and education is to cultivate a sense of collective public responsibility to respond to public warnings. Drawing on his experience in Australia, he reflected that "we realized very quickly that they saw the emergency alert capability as a community alerting capability" in the sense that family members and neighbours would assist those who may not receive an alert or who may need extra help to respond.[35] Mr. Hallowes emphasized that, provided that community education has been effective, public crisis communications will work if they are relevant, timely, and accurate.

Principle 5: Evaluating and Learning from a Critical Incident Response

The fifth principle that emerges strongly from international policy reports and research is the importance of evaluating an organization's actions after a critical incident, whether the response went well or not. Dr. Kruke explains in his expert report that critical incidents "provide learning opportunities for preventive initiatives in the pre-crisis phase and improved disaster responses in the acute phase," if only we look for these opportunities.[36] He emphasizes that "[l]earning is not

correlated with blame"; nor is it "only about mistakes."[37] Examining and sharing lessons learned on what went well *and* what fell short is important for community safety. The focus of post-incident learning should primarily be organizational and systemic:

> **[W]hen conducting investigations following mass shooting events, it is imperative to look beyond specific actions by response personnel and seek a deeper understanding of what led them to make such decisions during such a response. There may be relevant explanations at the organizational and systemic levels that could provide a richer understanding of specific actions / inactions at the field level.**[38]

The value of systematic study of critical incident responses is demonstrated by the work of the Advanced Law Enforcement Rapid Response Training Unit (ALERRT) at Texas State University in San Marcos. Formed in 2002 in response to the recognition of a need for standardized active shooter response training for the patchwork of law enforcement agencies in the San Marcos area, ALERRT became the FBI's designated National Standard in Active Shooter Response Training in 2013. In addition to offering training to law enforcement and medical response units, ALERRT maintains an active researcH Division that "conducts original research on law enforcement active shooter response tactics."[39] Among other research activities, ALERRT conducts close evaluations of critical incident responses. Its training courses have evolved to incorporate the lessons learned from its research. In our roundtables on critical incident response, we heard from ALERRT's director of research, Dr. Hunter Martaindale, and his colleague Dr. Matthew McAllister. ALERRT's executive director, Dr. J. Pete Blair, had been scheduled to join us but was unable to do so because ALERRT was retained to assist with an after-action review of the mass casualty that occurred in Uvalde, Texas, on May 14, 2022. In this incident, a perpetrator shot and severely injured his grandmother before going to Robb Elementary School, where he killed 19 students and two teachers, and wounded 17 others.

The RCMP's "Immediate Action Rapid Deployment" (IARD) approach to training members in active shooter response reflects some of the lessons that have emerged from the work of ALERRT and similar organizations. Other improvements in critical incident response that have come from ALERRT's research include protocols for providing emergency medical care to injured victims while law enforcement personnel are still responding to an active threat; and generating models of

integrated command, in which leaders from all responding agencies are placed in a single location so they can work together with "a clear chain of command."[40] As Dr. Martaindale and his co-authors have explained, "The priority for all first responders is to save lives. This training gives them tools to work more efficiently to reach that goal."[41]

Evidence of the value of studying past incidents for organizational learning is supplied in the Orlando Pulse nightclub report. The authors of this report identify:

> The attack on the Pulse nightclub challenged Orlando public safety leaders and their personnel as they confronted threats and other issues they had not previously encountered. However, many members of the command staff, mid-level leaders, members of specialized teams, and patrol officers advised the assessment team that they had studied critical incident debriefs and reports from similar incidents and believe that, as a result, they were better prepared for some of the challenges that emerged during the incident.[42]

The authors provide concrete examples of actions the Orlando Police Department took differently on the basis of lessons learned from past after-action reports. The department commissioned the independent and comprehensive review of its response to the Pulse nightclub mass casualty in order both to learn from its own work and to contribute to others' understanding:

> OPD Chief Mina … acknowledged learning from critical incident reviews of previous mass casualty and terrorist attacks … Critically assessing the response to a major incident is commendable and essential to learning and improving individual agency, regional, and national response capabilities.[43]

Fortunately, Canada has not experienced the same number or scale of mass casualty incidents as has the United States. We are grateful to US and international commissions, researchers, and police leaders who have studied incidents in their own jurisdictions and made the lessons that emerge from these incidents available to others. We encourage Canadian police and emergency response organizations to study the reports and research that are summarized in this chapter. It is also clear from this literature that there is great value in reviewing every large-scale

critical incident response, to ensure that the opportunity to learn lessons is not squandered.

Studying responses is a necessary step to improving future actions, but the potential benefit can be realized only if the organization implements change in response to the lessons learned from such study. As Dr. Kruke observes, "Learning is in many ways about changing behaviour based on the recommendations in after-action reports. In change, we see that learning is a priority."[44]

Conclusion

In this chapter, we have identified five principles of effective critical incident response that emerge from the extensive international literature. These principles are not new, and there is a strong consensus around the importance of each of them.

The five principles of effective critical incident response are:

1. Preparation for critical incident response is key to the quality of a critical incident response.
2. "The next crisis has never happened before."[45] Every critical incident is unique, and so preparation and training must equip decision-makers and responders to operate effectively in conditions of considerable uncertainty.
3. Interoperability is a fundamental attribute of an effective response, and a culture of trust and coordination between and within agencies must be generated well before a critical incident happens. Technological solutions alone cannot foster effective interoperability.
4. Community members are the first responders to a critical incident, and they have the potential to be a crucial resource for professional responders. Clear, accurate, and timely public communications are indispensable during a critical incident response.
5. Effective organizations take the opportunity to study critical incident responses for two principal reasons: to identify lessons that may be learned, and to implement change in response to those lessons.

Notably these principles emerge as strongly from the literature on critical incident responses to mass casualties in rural areas and small towns as they do from reviews of urban mass casualties. In his peer review report on the Cumbria police response to the 2010 mass casualty in West Cumbria, A/Chief Cst. Simon Chesterman of the English West Mercia Police force wrote:

> Police forces have to be ready to deliver a complex variety of services from providing visible reassurance to counter terrorism. Also, despite the contrast between policing a densely populated inner city area and a sparsely populated rural area, each force has a duty to deliver a service which meets the needs and expectations of their local communities.[46]

In her expert report for the Commission, Dr. Karen Foster, Canada research chair in sustainable rural futures for Atlantic Canada and associate dean of research in the Department of Sociology and Social Anthropology at Dalhousie University, identified an urban bias in research and policy studies of community safety. Dr. Foster cautioned us against the assumption that research generated in urban settings will translate well to rural challenges.[47] Her advice prompted us to look particularly closely at the reviews of critical incident responses in rural areas as we were conducting our literature review. Our conclusion from this review is that the implementation of the five principles of effective critical incident response may look different for rural policing in light of important differences in factors such as community resources, availability of other support services, and demographics. However, the fundamental principles of effective critical incident response apply with as much force to rural policing as they do to urban policing.

LESSON LEARNED

Five strong and consistent principles for effective critical incident response emerge from the literature on critical incident preparedness and best practices. When these principles are not followed, critical incident responses suffer. Ineffective critical incident responses can result in more casualties and cause damage to community trust in police and other emergency services.

Recommendation P.1

PRINCIPLES OF EFFECTIVE CRITICAL INCIDENT RESPONSE

The Commission recommends that

All Canadian police agencies should implement five principles of effective critical incident response:

1. Prepare for critical incidents before they happen, first by acknowledging that they can arise, by training personnel, and by establishing clear roles and responsibilities for critical incident response.
2. Recognize that every critical incident is unique, and therefore that training and preparation must equip first responders, communications (911) operators, supervisors, and commanders to make decisions and act in conditions of considerable uncertainty.
3. Ensure that planning, policies, and training include other agencies that will be involved in a critical incident response, fostering a culture of interoperability among emergency responders.
4. Recognize that affected community members are the "true first responders" to a critical incident, and that they will play a crucial role in any critical incident response including by providing information to police and communications operators. Police agencies should engage in clear, timely, and accurate public communications, including information that will help community members to protect themselves and others, during a critical incident.
5. Evaluate every critical incident response after it takes place, whether the response went well or not. Identify lessons learned, areas for improvement, and practices that should be emulated. All personnel who are involved in a critical incident response should be included in a post-incident evaluation. In turn, these lessons should be shared in purposeful and coordinated ways to ensure institutional and public learning.

In the following chapters of Part A, we draw on these five principles to evaluate the critical incident response of April 18 and 19, 2020.

CHAPTER 2

Critical Incident Command and Decision-Making

CHAPTER 2 Critical Incident Command and Decision-Making

The RCMP defines a critical incident as "an event or series of events that by its scope and nature requires a specialized and coordinated response."[1]

Dr. Morten Sommer and his colleagues define the concept of command and explain the importance of having a clear command and decision-making structure in an article in the *International Journal of Disaster Risk Reduction* (2017). This article reviews some key concepts in emergency response and considers "how police officers with command responsibilities learn to carry out emergency response work and manage emergencies."[2] They explain:

> When an emergency occurs, especially a major emergency, the emergency management system is put into action to manage the incident. Many things will require more or less immediate attention, and numerous tasks must be taken care of both on-scene at the incident site and off-scene at the response organizations and within the affected community. To bring order to the "chaos" and deal with everything in an efficient way, a command structure must be established. Within this structure, different commanders must exercise command. *Command* is essentially about exercising authority and having the responsibility for organizing, coordinating, directing, and controlling personnel and resources to achieve a given aim and ultimately manage the incident …
>
> *Decision-making* is an essential part of this process, which is a continuous cycle of situation assessment (gathering and interpreting information about the situation to find out what is happening and anticipating how the situation will develop), making decisions (deciding what to do and selecting a course of action), implementing decisions (taking action oneself or giving orders to others to get them to carry out the selected course of action), and reviewing and following-up (checking if the actions

> are carried out as planned and evaluating how this affects the situation) that continues until the response is completed.[3]

Sommer and his colleagues emphasize that coordination is key to the effective exercise of command. Coordination depends on team members having "a common understanding of the situation," ensuring that information which is communicated is received and understood by those with whom it is shared. It also involves having mutual trust that all team members will contribute their part, share necessary information, and co-operate.[4]

In a roundtable, Dr. Kimmo Himberg, former rector of the Finnish Police University College, emphasized the importance of clarity in a command structure, explaining that there must "never be a situation where it is unclear who is leading the situation, who is leading" the police response.[5] The Commission also heard testimony from RCMP critical incident commanders who agreed with the importance of ensuring that everyone involved has a clear understanding of the command structure: "[I]t is part of our training to ensure that people know, (a) who's in charge, (b) what the mission is, and then pertinent information as you go forward."[6]

We also heard evidence from Supt. Wallace Gossen of the York Regional Police, who teaches critical incident command in Ontario and is himself an experienced critical incident commander. He suggested that as an incident increases in scope and additional personnel are added to the response beyond the initial responders, challenges can arise:

> When the men and women first show up to those events, they're going to respond to the way that they're trained and they're going to do those things. But as those events increase in scope and complexity and command starts coming in, typically, we find that that is where it begins to break down. And when you look at large events … Who's in charge; right? Where does the decision making lie, and do we all agree that that's the person who is in charge to make those decisions?

Supt. Gossen explained that the training given to critical incident commanders in Canada is designed to ensure that clear protocols are in place to avoid uncertainty about roles and responsibilities. This training is standardized across Canada, to ensure that critical incident commanders from one police service can work with those from another. A key principle is that the critical incident commander should "take command as soon as they have the recommended situational awareness."[7]

The challenges Supt. Gossen described arose on April 18, 2020, as the critical incident response was scaled up from the first four RCMP responders (who arrived in Portapique at approximately 10:30 pm on April 18) and before the critical incident commander took command at 1:19 am on April 19. In this chapter, we identify several command and supervision–related reasons for these difficulties. We begin by describing what we learned about the status and content of some key RCMP planning and guidance documents and evaluate the RCMP's preparedness for a complex critical incident response in Nova Scotia. Second, we set out some of the key principles of critical incident command and describe RCMP policy with respect to the initial command of critical incidents. Third, we explain that contrary to RCMP policy, no scene commander was designated in Portapique for the first several hours of the critical incident response. Fourth, we review the evidence and submissions pertaining to who had command of the critical incident response before the critical incident commander took command at 1:19 am on April 19. Fifth, we turn to the report written in 2014 by the retired assistant commissioner of the RCMP, Alphonse MacNeil, and his recommendation that supervisors receive better training in critical incident management and supervision – and we evaluate the effectiveness of measures taken by the RCMP before April 2020 to implement this recommendation. Finally, we turn to the role of the critical incident commander and discuss the impact of S/Sgt. West's decision to defer assuming command until after he arrived at Great Village and set up a command post.

Operational Guidance and Emergency Operational Plans

In Chapter 1, we explained that **preparedness is universally identified as a core principle of effective critical incident response, and that learning the lessons from past incidents is one effective way to prepare better for the future.** In this section, we consider some key aspects of the RCMP's preparedness in April 2020 for a major mass casualty incident in Nova Scotia. In the Moncton mass casualty incident in June 2014, the lives of three RCMP members were taken, two members were seriously injured, and many others were affected. The subsequent MacNeil Report (December 2014) prompted a flurry of activity with respect to active

shooter preparedness at both the national and the divisional level. Although RCMP national headquarters had primary responsibility for implementing changes in policy and training in response to Ret'd. A/Commr. MacNeil's recommendations, divisional leadership also had an important role to play.

Relatively early in the Commission process, the RCMP produced a document titled *C3 – Command, Control and Communications: Response and Planning Guide* [*C3 Guide*]. Officers from the RCMP's Atlantic Regional Council of Criminal Operations prepared this document in the fall of 2015. At that time, C/Supt. Marlene Snowman was the criminal operations officer in H Division, having been promoted from her role as officer in charge of the Codiac detachment – whose members were the first responders in the Moncton mass casualty. In that capacity, she had attended the scene in Moncton, visited wounded members in hospital, and performed next of kin notifications for family members of those whose lives had been taken. She also coordinated aftercare for the wounded members and their families. In her testimony, A/Commr. Lee Bergerman explained that this experience affected C/Supt. Snowman deeply and made her committed to RCMP preparedness for critical incident responses in the future.

The *C3 Guide* explains that it "is designed to prepare our members and our Divisions for *Command, Control* and *Communication* during the initial response to sudden and major policing events."[8] The document further explains:

> This is not a one-time read or nice to have, it's the very core of frontline policing in today's environment. These are the tools our leaders require in a crisis. The premise behind this material is, somebody must be in charge, everybody must know who is, information must flow back and forth in a crisis and the police response must be structured and controlled by a central point, the incident commander. Members have to be given clear direction … The public expects more and our members expect more … **This tool is critical job related information and as such must be widely available and accessible to as many members as possible.**[9]

The authors state that senior constables and non-commissioned officers should receive a copy of this document and that supervisors and managers should ensure that it becomes part of day-to-day management and the operational development of supervisors. The *C3 Guide* emphasizes that the "intent of this document is to ensure the RCMP's preparedness to react effectively at all levels."[10] It contains a

great deal of valuable advice and information, and specifically acknowledges the importance of preparing for critical incidents:

> **General duty members must anticipate these events through preparedness and planning. Supervisors and managers must facilitate this preparation and planning in general day to day supervision.**
>
> **All program managers and supervisors are directly responsible** for outcomes and ensuring that members are aware of the risk environment and response actions necessary for both planned and sudden (unplanned) major policing events. Although an active shooter or a terrorist event is sudden and unplanned, we must be prepared to the extent possible because such events can occur anywhere.[11] [Emphasis in original.]

The document also reiterates several of the other key principles identified in Chapter 1 – for example, interoperability: "During an actual major incident, **no one agency,** including police, works alone."[12] It emphasizes that the "role of the 'ad hoc' first responder Incident Commander is critical to the final resolution of the event."[13]

By April 2020, some parts of the *C3 Guide* had been superseded, including by training materials developed by RCMP national headquarters in response to the MacNeil Report recommendations. However, the *C3 Guide* itself has not been updated, nor has it been replaced with any similarly clear and comprehensive equivalent document. Indeed, C/Supt. Christopher (Chris) Leather, who was H Division criminal operations officer in April 2020, advised that he first became aware of the document after the mass casualty, "as a result of a disclosure requirement" for the Commission.[14] He explained, "it was very ad hoc, if I'm being frank, the way it came to my attention."[15] C/Supt. Leather identified that the RCMP does not require a transitional period or orientation for incoming senior officers, nor does it require that a briefing package or other means of conveying key portfolio-related information be produced by an outgoing officer. He explained:

> The corporate memory loss, whether it relates to the MacNeil recommendations, other key material that my predecessor learned over her four-year tenure, I've only become to learn through my own reading and file reviews, which has been self-directed. And it puts anyone coming into a position like that at a real disadvantage, and I hope that our organization will consider the importance of stronger transitional planning.[16]

Despite C/Supt. Snowman's motivation to ensure better preparedness, **the RCMP appears to have had no institutional mechanisms to ensure that the *C3 Guide* was incorporated into the leadership responsibilities of managers and supervisors, and that the insights shared in the *C3 Guide* were taken up by RCMP members and leaders.** Because critical incidents of this scale are rare, preparing for them requires leadership to make space for learning and practice. The comprehensive and useful *C3 Guide*, which is plainly the product of a great deal of work and careful thought, was evidently shelved. Members who responded to the mass casualty of April 18 and 19, 2020, seem not to have had the benefit of that work.

As we explained in Chapter 1, Dr. Bjørn Ivar Kruke emphasized in his expert report for the Commission that preparedness and learning are linked in the critical incident response cycle. Better preparedness for next time is in large part a product of institutional motivation to capture and implement the lessons that have emerged from previous occasions. **An organization can implement lasting lessons from past mistakes only if it takes active steps to capture and share institutional memory over time.** C/Supt. Leather identified that the failure to secure the lasting benefits of lessons learned may be an institutional weakness of the RCMP: "This can't be perishable and that we look at things like the effect of transitional plans and things like that as a way to ensure that the learnings don't fade when members retire, resign, and move on in the senior leadership positions, because I'm afraid that could happen."[17]

The national RCMP *Operational Manual*, Chapter 13.4, provides at clause 3.1.1 that "[a]ll Detachments will have EOPs [emergency operational plans] based on divisional direction."[18] Clause 3.2.1 states that "[f]unctional EOPs will be completed by all divisions."[19] Clause 3.2.2 provides that "[e]vent-specific EOPs will be completed based on the regional risk-assessment."[20] Clause 5.3 states: "Lessons learned, in the form of updates to the appropriate EOP, from each exercise or event must be incorporated as soon as possible, and no later than 90 days after the exercise or event unless exigent circumstances exist."[21]

The purpose and value of emergency operational plans was explained in an after-action review produced by the RCMP following the October 22, 2014, shootings on Parliament Hill in Ottawa. In this incident, a Canadian soldier was shot and killed by a perpetrator who then entered the nearby Centre Block of the Parliament Buildings. The perpetrator was killed in an ensuing confrontation with police. The RCMP's National Division Review Team conducted the after-action review to

"examine the RCMP's actions following the gunman's entry into the Centre Block," among other matters.[22] The team explained:

> Operational plans are predefined courses of action that culminate into an overall response that is believed to have the highest probability of achieving success, relative to an organization's strategic and tactical goals and objectives. Emergency Operational Plans (EOPS) combine the four interrelated actions of preparedness, mitigation, response and recovery relative to an emergency situation / critical incident, like the events of October 22nd, 2014. In crisis situations, organizations shift into a reactive mode, and the likelihood of communication breakdowns increase [*sic*]. An EOP strives to alleviate the potential impact of communication breakdowns on operational responses by:
>
> - Assigning responsibility to organizations and individuals for carrying out specific actions at specific times and places relative to a specific situation;
> - Clearly defining governance structures (authorities and organizational structures);
> - Detailing how resources (human, financial and capital) will be protected during an emergency;
> - Identifying the resources available for use during the response to an emergency situation; and
> - Articulating mitigation strategies that are acceptable in responding to an emergency situation.[23]

In short, **emergency operational plans assist an organization to prepare for a critical incident, so that when a crisis arises, questions such as roles and responsibilities or access to resources have already been determined in advance.** The national RCMP emergency operational plan policy states even more directly that "the purpose of EOPs is to establish response procedures to emergency events"[24] and that "appropriate EOPs will be used to respond during emergencies or events."[25] The national policy provides that emergency operational plans should be reviewed at least once every five years and that "lessons learned, in the form of updates to the appropriate EOP, from each exercise or event must be incorporated as soon as possible" after an event, and no more than 90 days later unless there are exceptional circumstances.[26]

An H Division *Emergency Operations Plan: Violent Crime in Progress* [2011 *Violent Crime in Progress EOP*] was produced relatively early in the Commission process. This document is dated May 31, 2011, and was approved by Supt. Brian Brennan in his role at that time as acting officer in charge of the Criminal Operations Branch. It states that the *Violent Crime in Progress EOP* is intended to establish "Procedures and Guidelines for reaction to violent crimes in progress and will provide direction on establishing containment to ensure public and police safety as well as protocols to assist in the apprehension of criminals as well as collection and preservation of evidence."[27]

The 2011 *Violent Crime in Progress EOP* provides guidance on a range of topics including the availability of RCMP support services, the role of the Major Crime Unit, and "how the Division will direct and control its response" to a violent crime in progress.[28] It explains the role and responsibilities of the criminal operations officer, the district policing officer, the district emergency operations centre commander, and the "incident commander."[29] We have not reviewed or been alerted to any other document that sets out these roles and responsibilities so clearly or in one place. The document also lists tasks that should be performed by first responders, including, for example, to "identify critical infrastructure, which may be impacted" and to "communicate with property owners within an impacted area."[30] It advises responding members "[w]hile en route, notify [a] supervisor, mentally note any activities that could potentially relate to the [incident] … vehicles; persons on roadway – potential witnesses / suspect(s). Report your observations immediately to secondary responding Units to assist."[31]

As with the *C3 Guide, the* 2011 *Violent Crimes in Progress EOP* has been superseded in some respects. For example, it does not account for the Immediate Action Rapid Deployment (IARD) approach to active threats that the RCMP now teaches to all general duty members.

We asked counsel for the RCMP to advise us of the present status of the 2011 *Violent Crimes in Progress EOP*. On February 27, 2022, we received information that this document was "not in use in April, 2020, and had been overtaken by subsequent changes to policy and training pertaining to critical incident responses." Accordingly, on March 2, 2022, we subpoenaed documents relating to the replacement of this document.

On October 14, 2022, **counsel for the RCMP confirmed that, at the time of the mass casualty, "there were no present H Division EOPs specific to violent critical incidents like mass shootings."**[32] This letter also provided a lengthy list of training

and policy documents that had overtaken the 2011 *Violent Crimes in Progress EOP*, including materials associated with the ICIR [Initial Critical Incident Response] 200 course and the introductory ICIR 100 course. These two courses were designed in response to recommendations in the MacNeil Report, and we return to them later in this chapter. For now, **we note that no member of the April 18 and 19, 2020, command group had completed ICIR 200 training, and only one had completed the ICIR 100 course. Furthermore, the RCMP national policy and the explanation provided by the National Division Review Team in the Parliament Hill after-action review suggests that an emergency operational plan serves a quite different purpose from training materials. However, we received no evidence about how the 2011 *Violent Crimes in Progress EOP* was actually used in supervision or in the day-to-day work of general duty members.**

The list of relevant documents provided by counsel for the RCMP also includes RCMP policies, including the national policy regarding emergency operational plans. Other national RCMP policies listed in this letter refer to the *Initial Critical Incident Response* guide, the role of the critical incident commander during a critical incident response, and the role of the Emergency Response Team. However, these policies and the documents referred to in them provide neither the same operational guidance to front-line responders nor the information about leadership roles and responsibilities that was formerly provided in the 2011 *Violent Crimes in Progress EOP*.

The RCMP also produced two emergency operational plans. The first, the 2014 *RCMP Division Emergency Operations Plan: Functional Activities* [*Functional Activities EOP*], has not been updated since the MacNeil Report was published. It explains that "the foundation from which these Functional Activities flow is the Event Site Management EOP, as any event must have a site from which it is managed."[33] No event site management EOP was produced to us or referenced in the letter of October 14, 2022, from the counsel for the RCMP. The *Functional Activities EOP* describes a range of activities that may be associated with a critical incident response, including traffic control, site security, and damage assessment. A section dedicated to "mass casualty" focuses on search and rescue for survivors and the recovery and appropriate management of human remains.[34] It addresses concerns about the impact of critical incident stress on members tasked with responding to a mass casualty, and also provides for the recovery of personal property. Again, this document does not provide the guidance formerly given in the 2011 *Violent Crimes in Progress EOP*.

The second emergency operational plan the RCMP produced is a template *H Division Emergency Operations Plan* dated March 30, 2015. This document provides a template for detachments to adapt as they prepare their own specific emergency operational plan, as anticipated by the national RCMP emergency operational plan policy. The document states that "[d]istricts and detachments will obtain detachment specific topographical maps from provincial lands, and these will be maintained for emergency planning and containment."[35] It sets out the operational priorities for emergency responses and provides, for example:

> RCMP Detachments, where they are the police service of jurisdiction, will be responsible for providing the initial police response to an event. Based on an initial assessment of the nature and extent of the emergency, the senior or most qualified responding member as decided by the Watch Commander will take the lead, participate in a unified command or assist the lead agency.[36]

The *H Division Emergency Operations Plan* also states that "Divisions, Districts and Detachments are all to maintain Mobilization Plans."[37] These plans set out how to "place members on standby and mobilize resources."[38] The template document is evidently intended to apply to a range of potential incidents including natural disasters and other forms of civil emergency. It is not specific to an active threat or violent crime in progress. Notably, the ICIR 200 training materials refer repeatedly to detachment-level emergency operational plans and the information they should contain.

Despite the national policy requirement that detachments maintain an emergency operational plan, there appears to be no detachment emergency operational plan for the Bible Hill RCMP detachment. The critical incident response of April 18 and 19, 2020, was initially coordinated from this detachment, and Portapique **is in Bible Hill's jurisdiction. Indeed, the only detachment or district-level emergency operational plan we received in response to our subpoenas was for the Victoria County District, located in Cape Breton, NS**. This plan provides helpful and specific guidance with respect to the roles and responsibilities of general duty members, front-line supervisors, and the district commander.

When Commission counsel asked C/Supt. Darren Campbell, whose portfolio as support services officer included emergency planning, about Emergency Operational Plans in H Division, he responded:

> There would have been Emergency Operational Plans that would have existed … I know that there are plans in existence … I can't recall seeing or being briefed on updating of any plans, but it's possible it happened. It just wasn't making it up to my level.[39]

More specifically, Supt. Campbell suggested: "I would imagine there's active shooter EOPs that were in existence at the time" of the mass casualty.[40] He indicated that it would be "a unit level manager responsibility" to make sure that all RCMP employees know about and understand emergency operational plans.[41] Glenn Mason, the RCMP H Division's emergency planning coordinator, suggested that detachment emergency operational plans may not have been a priority for detachment-level leadership:

> Someone is there at the detachment, and they come in and they write the EOP plan, and no one has really looked at it for four or five years because "I'm too busy to sit down and spend three hours reading and rewriting this plan. I've got other things to do."
>
> And that's … I guess that comes back to being overworked, lack of manpower, maybe lack of desire. I don't know. But a lot of it; it's not important until it's important, unfortunately.[42]

If such plans existed in April 2020, the command group appears to have been unaware of them, and they did not play any part in the critical incident response. Based on the comprehensive letter we received from counsel for the RCMP in reply to our subpoenas, we conclude that, despite the requirements set out in national RCMP policy, no Bible Hill detachment emergency operational plan and no H Division violent crime in progress emergency operational plan was in place at the time of the mass casualty.

Some context for the lack of RCMP emergency operational plans may be given by evidence we heard from RCMP personnel and former members about the Emergency Management Section in H Division. Supt. Dustine Rodier, the officer in charge of operational support and communications centre, and Mr. Mason both advised us that this section was persistently under-staffed and/or staffed with temporary personnel. At one time before the mass casualty, Insp. Rodier (as she then was) was performing the roles that should have been filled by two staff members in addition to her other responsibilities as manager "because there was no-one in the unit."[43] She characterized Emergency Management Services as "a

specialty" that requires someone with a background in emergency management, business continuity and the ability to manage high-risk units.[44]

The RCMP had requested additional funding and positions from the province to staff the Emergency Management Services unit, but it was unclear on the evidence provided to us whether the failure to fill these roles was attributable to a lack of funding or to a lack of qualified personnel. Counsel for the Province of Nova Scotia emphasized that the "Province has provided continuous funding to the RCMP for Provincial policing as set out in the PPSA [Provincial Police Services Agreement], including for emergencies and other events."[45] Former Nova Scotia minister of justice Mark Furey, who was an RCMP member until 2011 and had worked in this unit when it was fully staffed, told us that the unit did "a lot of work for two people" and that additional staffing "would have allowed greater attention" to be paid to the myriad responsibilities of the unit.[46] Persistent understaffing of the unit that has primary responsibility for emergency preparedness likely contributed to the failure to update operational guidance and the lack of up-to-date emergency operational plans in H Division.

MAIN FINDING

Contrary to national RCMP policy, in April 2020 the Bible Hill RCMP detachment had no emergency operational plan in place, and, similarly, H Division had no violent crime-in-progress emergency operational plan. The 2011 *Emergency Operations Plan: Violent Crime in Progress* did not reflect current policies or training and was not in use at the time.

The 2014 MacNeil Report recommended that each RCMP Division should "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."[47] This recommendation had been implemented in Nova Scotia, where district commanders were in 2015 directed to list "critical locations … that would be necessary to either set up road blocks or checkpoints to contain a threat from moving across or leaving or entering the province."[48] A list of locations generated in response to this direction was produced to us. However, the two trained critical incident commanders who were engaged in the critical incident response from 1:19 am to 10:20 am on April 19, 2020 (that is, before and during the time when the perpetrator became an active mobile threat in Nova

Scotia), advised us that they were unaware that any document or plan had been produced in response to this recommendation. Supt. Campbell was also not aware of this emergency operational plan.

MAIN FINDING

H Division had implemented the MacNeil Report recommendation to establish an emergency operational plan that identified major transport routes and critical locations to stop or contain an active threat from moving across the province. However, those in command of the critical incident response of April 18 and 19, 2020, were unaware of the existence of this plan, and it was not used during the mass casualty.

Recommendation P.2

EMERGENCY OPERATIONAL PLANS

The Commission recommends that

The RCMP should ensure emergency operational plans are current and utilized throughout all divisions.

As this lengthy account of RCMP policies, plans, and training materials indicates, it is unlikely that any general duty member, front-line supervisor, or risk manager tasked with responding to the April 2020 mass casualty would have known where to find the clear and specific guidance formerly provided in the 2015 *C3 Guide* and the 2011 *Violent Crime in Progress EOP*. Some of this information is now found in the *Initial Critical Incident Response Quick Reference Guide*, to which we return later in this chapter. However, much of the straightforward advice and direct guidance about roles and responsibilities that were provided in these earlier documents were not replicated in the revised policies and training materials.

H Division has not complied with national RCMP policy with respect to the creation and maintenance of emergency operational plans. Efforts have been made at times by individual leaders to improve H Division's preparedness for critical

incident response and to generate documents that would support supervisors and general duty members to learn and prepare. However, the RCMP appears to lack institutional mechanisms to sustain these efforts and to realize their benefits. In particular, the 2015 *C3 Guide* and the 2011 *Violent Crimes in Progress EOP* have not been kept up to date, nor have they become the central guiding documents that would, if they had been current and widely read, have provided considerable assistance during the critical incident response of April 18 and 19, 2020.

In the balance of this chapter, and in Chapters 3 and 4, we assess the implications of this lack of operational guidance. In particular, we identify that **many of the lessons arising from the critical incident response in Moncton appear to have been forgotten or sidelined by April 2020 despite efforts by the Atlantic regional criminal operations officers to capture these lessons in the 2015 *C3 Guide*. Institutional forgetfulness of the existence of the emergency operational plan with regard to critical transport locations, which was produced in response to a MacNeil Report recommendation, is one example of this overall trend.** We identify further examples throughout Part A of this volume.

RCMP Planning and Preparedness for Complex Critical Incident Response in Nova Scotia

As we set out in more detail in Volume 2, What Happened, the first critical incident commander (CIC) to be engaged in this mass casualty incident was S/Sgt. Jeffrey (Jeff) West. He received a phone call from Acting Insp. Stephen (Steve) Halliday at 10:42 pm on April 18, 2020. Acting Insp. Halliday was the acting district operations officer for the RCMP's Northeast Nova district in Nova Scotia, and the most senior member of the district command structure to become directly involved in the critical incident response. Acting Insp. Halliday made two requests of S/Sgt. West: that he deploy as critical incident commander; and that the critical incident package of support services, including the Emergency Response Team, a crisis negotiator, and a scribe (an individual trained to take notes), also be engaged. S/Sgt. West called Supt. Darren Campbell, the support services officer, at 10:46 pm to initiate

this deployment. As we explain below, however, almost three hours elapsed before he took over command from the risk manager, S/Sgt. Rehill, at the Operational Communications Centre. In other words, RM Rehill was the de facto commander at the outset of the critical incident response.

S/Sgt. West was based at the RCMP headquarters in Dartmouth. He explained later that he received an initial briefing from Acting Insp. Halliday and that, as he drove toward Great Village from Dartmouth, he had "been on the phone with Steve Halliday, been on the phone with [Emergency Response Team leader Cpl. Timothy] Tim Mills kind of getting everything going."[49] However, he also said he was not able to monitor radio communications or review the incident activity log (the CAD log) in the RCMP Computerized Integrated Information and Dispatch System (CIIDS) that is intended to capture key information about an incident and the response to it. CIC West took command at 1:19 am on April 19, 2020, after arriving at the Great Village fire hall and setting up his command post.

RCMP policies and procedures with respect to critical incident command are largely premised on the active engagement of a critical incident commander who is in command of the critical incident response. The *RCMP Tactical Operations Manual*, which gives general guidance about the structure of response to potentially violent incidents, sets out in Chapter 1.1 the role and responsibilities of the critical incident commander:

> 1.1 When activated during a critical incident, the Critical Incident Commander has overall command and control of the critical incident, until:
>
> 1.1.1 it is no longer deemed a critical incident, or
>
> 1.1.2 that person is relieved by another Critical Incident Commander, who assumes command.[50]

Clause 6 of this policy clarifies that, on taking command of a critical incident, the critical incident commander has many responsibilities, including the following:

> 6.1.1 command and control of the incident and all related resources;
>
> 6.1.2 using [critical incident command] principles to resolve the incident, including but not limited to:
>
> 6.1.2.1 ensuring that liaison is established and intelligence shared with support units;

6.1.2.2 assessing the situation, requesting required resources, assuming overall command, and unless exigent circumstances exist, attending the scene;

6.1.2.3 assessing containment and evacuation efforts;

6.1.2.4 establishing a command post;

6.1.2.5 ensuring decisions are recorded by a scribe;

6.1.2.6 authorising negotiations;

6.1.2.7 approving operational plans;

6.1.2.8 conducting appropriate briefings and debriefings;

6.1.2.9 approving the release of information to the media;

6.1.2.10 ensuring effective transition of command; and

6.1.2.11 timely relief of the critical incident personnel.[51]

In his review of the RCMP's response to the 2014 Moncton mass casualty, Ret'd. A/Commr. MacNeil explained in his report that the critical incident commander is "responsible for the deployment of resources, the interaction of those resources, and maintaining the integrity of the command triangle."[52]

RCMP witnesses who were involved in the critical incident response testified that, in a critical incident response of the scale undertaken on April 18 and 19, 2020, these responsibilities are, in practice, delegated among a team of senior non-commissioned officers who are assembled to support the critical incident commander. In his testimony, C/Supt. Campbell explained the overall team approach and the role of the critical incident commander as follows:

> We don't have a single person that would be in a command post. There would be a team of people that would be supporting that Critical Incident Commander. For example, the Critical Incident Commander is in charge of the Critical Incident Package, as we call it. So they would have command authority over every resource, but they would be relying on the expertise and the input from other individuals.[53]

On April 18 and 19, 2020, this team included Acting Insp. Halliday, whom CIC West described as "the one that will make stuff happen for us with the uniform side of the house."[54] CIC West explained that "uniform command," the RCMP's district supervisory structure, plays a significant role in some crucial tasks – for

example, ensuring that a sufficient number of general duty members are available to perform duties such as controlling the perimeter of a critical incident response. However, he said, the critical incident commander works most closely with the "command triangle," which consists of the critical incident commander at the pinnacle of a triangle that also includes the Emergency Response Team (ERT) team leader and the crisis negotiator.[55] CIC West described the uniform command and the Major Crime Unit as being "under that triangle" once the critical incident commander takes command.[56]

Given the scale of this critical incident response, CIC West also called in a second critical incident commander, S/Sgt. Kevin Surette, to act as associate critical incident commander. S/Sgt. Surette was the second of two critical incident commanders who were on call in H Division (Nova Scotia) on the night of April 18 and 19, 2020. He had to drive from Yarmouth, NS, more than 420 kilometres from Great Village. He and S/Sgt. West agreed at about 12:30 am on April 19 that he would join the critical incident response, and he arrived at the command post at approximately 5: 40 am. In the period between CIC West taking command of the critical incident response and S/Sgt. Surette's arrival, they had two relatively brief phone conversations, only one of which was substantive. Both these witnesses emphasized that CIC West was ultimately in charge until he handed command over to S/Sgt. Dan MacGillivray at approximately 10:20 am on April 19. After transferring command, S/Sgt. West remained at the command post in Great Village as a resource to CIC MacGillivray.

RCMP policies also make it clear that other members of the RCMP work within the overall command of the critical incident commander. For example, the national *Tactical Operations Manual*, Chapter 2 provides that critical incident commanders "command, coordinate, and manage all resources in response to a critical incident." Within RCMP nomenclature, the term "resources" is frequently used to include RCMP members and equipment.

Supt. Gossen explained that critical incident commanders are taught "priorities of life" that should be pursued within their decision-making:

> [W]hat we teach the priorities of life for a commander is the exact same for the priorities of life of a frontline officer. It's the public, the officers, and the subject. So when they make those decisions, right, everything is contextualized within that framework.[57]

In other words, in making decisions, critical incident commanders and front-line members should prioritize safeguarding the lives of community members, followed by ensuring officer safety and the safety of the subject of the critical incident response. Critical incident commanders are trained to consider the necessity of a given action, whether it is risk effective, and whether it is an acceptable action in managing these priorities appropriately. CIC West's timeline of actions identify at 12:04 am on April 19, "Initial responding officers had heard gun shots and it was believed that the suspect was likely still in the Portapique area. This constituted a significant risk to residents and police. (Priorities of Life.)" Again, at 1:02 am, the records reiterate the priorities of life, and the same appears numerous times thereafter during his command.

In an expert report written for the Commission, Dr. Laurence Alison, chair of forensic and investigative psychology at the University of Liverpool, and Dr. Neil Shortland, director of the Center for Terrorism and Security Studies at the University of Massachusetts, Lowell, drew on their research using experimental and empirical methods to study critical incident decision-making and the mistakes decision-makers often make in that high-stress environment. They explain why it is important for critical incident decision-makers to have clarity about the relative priority of the values of life – particularly the relative safety of community members and the police:

> In a series of critical decision method interviews with members of "blue light" services (police, fire and rescue, and ambulance services), Power (2016) found that CIDM [critical incident decision-making] often placed "approach goals" and "avoidance goals" against each other. While approach goals influence tendencies to take positive action towards a positive stimulus, avoidance goals encourage individuals to avoid negative effects by moving away from a negative stimulus. Power interviewed 31 command level decision-makers from the Police Service, Fire and Rescue Service, and the Ambulance Service (AS) and asked them to recall a "difficult decision." The results showed that emergency commanders hold two overarching goals:
>
> 1. **Save life:** Goals and motivations associated with approaching positive outcomes from a situation; and
>
> 2. **Prevent further harm:** Goals and motivations associated with avoiding anticipated negative consequences

> Power's research found that these (competing) goals often resulted in uncertainty, goal conflict, passive and active avoidance, and inaction: "The 'save life' goal appeared to derail action if the decision-maker experienced goal conflict by trading it off against the competing avoidant goal to 'prevent further harm'" (Power, 2016: 96). For example, rushing into a burning building to save civilians risks the loss of police / ambulance / firefighter lives. Power (2016) found that emergency commanders are often faced with these two countervailing goals (saving lives of victims versus protecting lives of colleagues), and when a decision-maker cannot decide between them, decision inertia can be the result (Power & Alison, 2017). In our own research with members of the US military, Shortland and Alison (2020) have found that redundant deliberation emerges when individuals are forced to choose between two equally important values. Our findings indicate that when two equally "sacred" (non-negotiable) values collide, a decision-maker who finds each outcome intolerable will fall into the trap of redundant deliberation. By contrast, the ability to identify one clear important goal can protect against redundant deliberation (Shortland & Alison, 2020).[58]

We noted above that Supt. Gossen identified the period after the first responders arrive, and before the critical incident commander assumes command, as a time when it can be unclear who is in charge of the response and how roles and responsibilities are allocated. In his report, Ret'd. A/Commr. MacNeil found that, at this stage of the critical incident response in Moncton in 2014, there had been breakdowns in front-line supervision and command. Referring to the period after active shooting commenced and before a critical incident commander took control of the critical incident, he concluded:

> Nobody established a command presence during this period. Members were acting on their own accord without a unified tactical plan. Order could have been established if a supervisor had obtained a situational update and requested members report their positions. Most members at this time were on foot. Nobody at a supervisory level had an overall view of where resources were positioned and this remained the case for the next hour or more. Members were taking heroic and commendable action as individuals and in small teams, however, they were not coordinated with a common plan and direction.[59]

Ret'd. A/Commr. MacNeil accordingly recommended that "the RCMP provide training to better prepare supervisors to manage and supervise throughout a critical incident until a [critical incident commander] assumes command."[60] We evaluate the measures taken in response to this recommendation below.

With respect to the role of the Operational Communications Centre (OCC) in the same time period, Ret'd. A/Commr. MacNeil observed:

> Although the OCC was doing an exceptional job in coordinating the members on scene, a senior NCO with tactical experience posted to the OCC during this critical incident would have been in the best position to coordinate resources with real time, accurate information.[61]

For this reason, Ret'd. A/Commr. MacNeil recommended that a senior non-commissioned officer be posted to the Operational Communications Centre. His description of the skills appropriate for this position suggests that the selection of these officers should be based on their competencies and the responsibilities they may be asked to discharge during a critical incident. In H Division, the role that he envisaged is fulfilled by the risk manager.

RCMP policies provide relatively little direction about the command structure that applies before the critical incident commander takes command. Chapter 16.10 of the national *Operational Manual* relates to Immediate Action Rapid Deployment (IARD) – the tactics and policy that apply when "on-duty members must stop an active threat causing grievous bodily harm or death." This policy provides at clause 3.1.1 that initial critical incident command should be assumed by the first member on scene, "if circumstances and available resources allow."[62] However, clause 3.1.1 also makes clear that it is not mandatory for the first member to take initial command and that this approach may be precluded by other circumstances:

> [E]xigent circumstances may require that you enter the premises immediately as part of the initial deployment … and may prevent you from assuming command. You must, when practicable, provide continuous updates to the OCC and other responding members in order to designate or transfer initial critical incident command to the next available member.[63]

This provision cross-references clause 1.9, which provides that "[p]olice priority during an IARD is to stop the active threat, in accordance with the principles" of

applicable use of force policies.[64] This policy does not refer directly to the priorities of life or the preservation of life, though the priority of stopping the active threat clearly favours action over avoidance in the terms explained by Dr. Alison and Dr. Shortland in the passage quoted above.

The IARD policy anticipates that initial critical incident command will be exercised at the scene of the critical incident, first by an early responding member and later by a more senior member. Clause 3.1.7 provides that members responding on scene should "[e]nsure effective transition of command to a supervisor or unit commander, and finally to a Critical Incident Commander."[65] The supervisor or unit commander is instructed to ensure "that ERT and the Critical Incident Commander have been contacted and are kept updated of any developments."[66] However, the policy does not specify which supervisor or unit commander should assume command and control.

At the time of the mass casualty, Chapter 33.100 of the H Division *Operational Manual* contemplated the roles and responsibilities of responding members, the critical incident commander, and others. It states at clause 3.7 that the unit commander will "[a]ssume the position of operations commander until the arrival of the Incident Commander," but it does not describe the role of the risk manager.[67] A 2017 document titled "H Division OCC Risk Manager Roles and Responsibilities" explains that "[r]isk managers are trained incident commanders so in cases where immediate control needs to be provided (e.g. in high risk situations), they will provide it until such time as local supervisors can arrive on scene and take charge of the situation."[68] This document also states that risk managers will "[c]o-ordinate high risk incidents and manage all the resources, regardless of where they come from, until Incident Commanders can take control of the situation on site."[69] This responsibility extends to engaging specialized services such as the Emergency Response Team and members of the Police Dog Service.

An updated version of Chapter 33.100 of the H Division *Operational Manual*, now placed in the H Division *Tactical Operations Manual*, was adopted in January 2022, following the mass casualty. This updated policy provides a clearer explanation of the delineation of responsibilities between the risk manager and the initial scene commander. It anticipates that a member on scene will exercise "command of the initial critical incident response" and "will provide regular updates to the Risk Manager until the [critical incident commander] takes command of the incident."[70] The amended policy assigns specific responsibilities to the risk manager or delegate, but also provides at clause 2.6: "In larger, more difficult to contain events where the

initial commander is not in a position to gain situational awareness or is needed as part of the response (e.g. active threat), the Risk Manager may assume command up until the delegate or the Critical Incident Commander assumes command."[71] Therefore, both the national IARD policy and the updated H Division policy assume the presence of an on-scene commander.

The national IARD policy provides some detail about the responsibilities of a scene commander. For example, on April 18, 2020, this person's responsibilities included the following:

> 3.1.5 Immediately deploy available resources to stop the active threat …
>
> 3.2 When sufficient additional resources arise on scene, establish:
>
> 3.2.1 a command center,
>
> 3.2.2 an outer perimeter,
>
> 3.2.3 a controlled and safe approach route,
>
> 3.2.4 a safe staging area for first responders, ERT, CBRN [chemical, biological, radiological, and nuclear defence], EDU [Explosives Disposal Unit], paramedics and fire department,
>
> 3.2.4.1 additional contact teams and/or rescue teams, as determined by the continuous risk assessment[.][72]

Ret'd. A/Commr. MacNeil emphasized the importance of having both strategic and tactical supervision of responding members during a critical incident response. He also set out the challenges that arise when these roles are conflated or when a member of the supervisory team changes roles without clearly communicating that change. So, for example, he found that in the 2014 critical incident in Moncton:

> The [on-scene] road supervisor was the supervisor with the best situational awareness and may have been able to provide tactical direction from the scene. The [off-scene] Ops [Operations] NCO, who was alone in the office for the hectic half hour after shots were fired, was flooded with radio, telephone and other concurrent activity that was necessary to bring in additional resources. He did not have adequate situational awareness to provide proper tactical direction.[73]

Similarly, Ret'd. A/Commr. MacNeil observed that the on-scene supervisor had transitioned from his role of supervisor to that of first responder without first

discussing a tactical plan with other responding members. He also stated that the command structure for the incident response was unclear to responding members, particularly after the arrival of an inspector at the detachment. Moreover, those "on the ground were not made aware of the command structure."[74]

No Scene Commander at Portapique

The RCMP's Immediate Action Rapid Deployment policy contemplates that the initial response will include the designation of a scene commander, whose responsibilities include, for example, the deployment of an IARD response. The IARD responders' duty is to find the perpetrator and "stop the active threat" in accordance with the use of force procedures. When on the ground resources permit, the scene commander is also tasked with establishing perimeter and containment and identifying a safe place for the command post and for medical and fire responders to stage, or meet. The policy contemplates that these responsibilities will initially be exercised by one of the first responding members and that they will be transitioned to a supervisor or a unit commander when one becomes available.

> A scene commander is a member or supervisor who is physically present at the site of a critical incident, and who has taken responsibility for co-ordinating the on-scene response, including deploying an IARD response, establishing containment, and identifying a safe place for medical and fire responders to stage. Pursuant to RCMP policy, scene command may be exercised by a general duty member until a supervisor arrives on scene.

The IARD policy does not specify that a supervisor or a unit commander to whom such responsibilities are transitioned will be on scene, although many of the responsibilities assigned to the scene commander assume on-the-ground knowledge of the scene. Ret'd. A/Commr. MacNeil identified the importance of having on-the-ground supervision of responding members because this person would have situational awareness that is not available to those coordinating the response from a distance. In his testimony, C/Supt. Campbell also confirmed the

expectation that a scene commander will be in place. In his words: "[T]here might be a little bit of confusion there in terms of who's in charge, but there should be someone on-scene that is commanding the response in terms of the active shooter response."[75]

Supt. Phil Lue, an experienced critical incident commander who served as the director of the Critical Incident Program in RCMP national headquarters from March 2020 until July 2022, emphasized in his interview with the Commission the importance of having a scene commander on site. He also pointed to the differences between the responsibilities of the scene commander and those of the risk manager:

> There's a difference between an on-scene … like somebody who … like a general duty person, frontline officer that is at the scene that's in charge and then a risk manager being in charge … So, we teach in ICIR [Initial Critical Incident Response courses], first person at scene, if you're the first person there and there's still people coming and you're a constable with like three years' service, guess what? You might be in charge.[76]

Supt. Lue explained that a very junior member in this position would hand over to someone more experienced as soon as possible:

> And then the Risk Manager would be that … that experienced person, that if I was the person in charge of the scene, I could say, "Hey, Risk Manager, like, can you help me out here? Like, can you make some phone calls? Can you give me some advice or whatever it is I need, but I'm still at the scene here and I'm going to deal with this.
>
> COMMISSION COUNSEL: Before the CIC comes though, does there not need to be an ad hoc commander of some kind? Like, as you say, someone has to take charge.
>
> SUPT. LUE: Yeah, and that's usually somebody at the scene.[77]

In evidence before us, several witnesses suggested that Acting Cpl. Stuart Beselt was the scene commander in Portapique until the critical incident commander took overall command. The Attorney General of Canada similarly submitted on behalf of the RCMP that Acting Cpl. Beselt took "the role of incident commander" before S/Sgt. West took command.[78] The evidence demonstrates that Acting

Cpl. Beselt showed leadership throughout the night of April 18/19, 2020, and his actions show an understanding of the lessons emerging from Moncton in 2014. For example, he reminded fellow members to stop short of the scene to don hard body armour and ready their carbines as they were travelling toward Portapique, and he regularly provided those who were not at the scene with information about where the IARD responders were situated, what they were seeing, and what actions they were taking.

The evidence shows that Acting Cpl. Beselt initiated and led the IARD response in Portapique. At 10:28:24 pm on April 18, 2020, soon after stopping at the top of Portapique Beach Road to don his own hard body army, he radioed, "Found some victims here."[79] As we explain in greater detail in Volume 2, What Happened, this message referred to Andrew and Kate MacDonald, who had managed to drive away after the perpetrator shot and injured Mr. MacDonald. Acting Cpl. Beselt identified the possibility of other victims being present, then headed down Portapique Beach Road on foot with Cst. Adam Merchant to begin an IARD response. Cst. Aaron Patton continued speaking to the MacDonalds and radioed further information from them before running down Portapique Beach Road to join Acting Cpl. Beselt and Cst. Merchant. When these first responders testified, Acting Cpl. Beselt explained his thinking at this time, and Cst. Patton provided further information about the basis for their decision to leave the initial staging point to pursue the perpetrator:

> CST. STUART BESELT: Like, at the beginning, you know, we understand somebody has been shot; right? So that's – that's one call; right? But now that there's other people that have been shot, it transitions the – like, the call, to it's not just a shooting, it's an active shooter; right So now that kind of changes your thought process and your – how you're going in there, because you're going in under the IARD principles; right, which is to go in and stop the threat; right?
>
> CST. AARON PATTON: To add to that too, at this point we're still hearing heavy gunfire. Like, there's – throughout the night, there's a lot of explosions and a lot of times where we couldn't decipher necessarily if it was gunfire we were hearing or if it was explosions, or both. But at this point, there's distinct gunfire and it's rapidly being fired.[80]

The thought process that these members described amounts to the decision contemplated in the RCMP's IARD policy, section 3.1.1:

> According to current IARD training, exigent circumstances may require that you enter the premises immediately as part of the initial deployment in accordance with sec 1.9. **and may prevent you from assuming command**.[81]

Acting Cpl. Beselt's decision to move toward the active threat is consistent with section 1.9 cross-referenced in the above extract: "Police priority during an IARD is to stop the active threat" in accordance with use of force principles.[82] It is apparent from section 3.1.1 that leading the IARD response precluded Acting Cpl. Beselt from assuming overall scene command. The wisdom in this delineation of responsibilities is also evident: when Acting Cpl. Beselt was fully tasked with an IARD response at night, in a chaotic and dangerous environment, he could not possibly also have performed the responsibilities of initial critical incident command as contemplated in sections 3.1.2–3.2.6 of the IARD policy.

MAIN FINDING

Acting Cpl. Stuart Beselt was not the scene commander. Rather, he acted in accordance with RCMP policy by moving toward an active threat as the leader of an IARD response.

The responsibilities set out in sections 3.1.2–3.2.6 were not being performed or coordinated by another member on the ground in Portapique. As of April 2020, neither the national IARD policy nor the H Division *Operational Manual* clearly stated who had responsibility for designating a scene commander in the event that the first member on scene became part of the IARD response. These policies did, however, contemplate that a unit commander would assume command from general members on attending the scene. In his testimony, Sgt. Andrew (Andy) O'Brien explained that, under normal circumstances, if a serious incident arose, the operations non-commissioned officer or another supervisor would take over from the risk manager "when you arrive on scene."[83]

Sgt. O'Brien was, in April 2020, the operations non-commissioned officer for the Bible Hill detachment. He was off duty on the evening of April 18, 2020, and, as permitted to do on his own time, he had consumed alcohol. Sgt. O'Brien testified that he had consumed four or five ounces of rum between 6 pm and 10 pm on that evening. He was alerted to the unfolding incident in Portapique by Acting

Cpl. Beselt, who was driving toward Portapique as one of the first responding members. Sgt. O'Brien subsequently spoke to S/Sgt. Allan (Al) Carroll, to advise him that, because he had consumed alcohol, he did not feel he should attend the scene. Instead, Sgt. O'Brien went to the Bible Hill detachment, where he collected a portable radio.[84] He testified that he did not feel impaired, but he asked his wife to drive to avoid an adverse perception should he encounter members of the public.

Returning home, Sgt. O'Brien set up his laptop with the RCMP's CIIDS, which gave him access to the location of RCMP vehicles whose mobile work stations were logged in and to the CAD log, which contained information entered by call-takers and dispatchers about the incident. He first broadcast by radio at 10:37 pm on April 18, and continued broadcasting regularly throughout the night. The Attorney General of Canada stated in its final submission that Sgt. O'Brien should not have joined the critical incident response after drinking alcohol.

Senior RCMP witnesses offered differing interpretations of the RCMP's rules with respect to working while intoxicated by drugs or alcohol. The RCMP *Code of Conduct* reads:

> **4.3** Members on duty are fit to perform their duties and carry out their responsibilities and are not impaired by drugs, alcohol or other substances.[85]

For example, C/Supt. Leather testified: "[M]embers consuming alcohol and reactivating themselves or going in for duty is not – it's not just not ideal, it's not allowed by police. It's fairly clear in terms of intoxicants, whether it be alcohol or drugs."[86] Commr. Brenda Lucki offered a different interpretation, suggesting, "I would expect people, if they were going to come into work, that they would not be over the legal limit. That's what I – that would be our expectation, and as per our Code of Conduct."[87] S/Sgt. Carroll, who was Sgt. O'Brien's supervisor, attended to the "impairment" standard set out in the Code. He explained in testimony, "I had no concern about Andy's – he had a couple drinks and I was not concerned about his ability to function."[88] We consider that this uncertainty about the rule with respect to alcohol and drugs arises from the lack of specificity within the Code, which is poorly framed. The subjectivity inherent in a standard of "fit to perform their duties … and not impaired"[89] is evident in the range of evidence we heard from RCMP witnesses about how the standard translates to the circumstances in which Sgt. O'Brien deployed. Policing is difficult work, and it requires a range of skills including interpersonal and physical skills. We consider that the only appropriate

standard for RCMP members is that they have no alcohol or recreational drugs in their system when on duty. A member who has consumed alcohol or recreational drugs should not report for duty or self-deploy.

LESSON LEARNED

Police agencies should have clear rules about the consumption of alcohol and recreational drugs while police officers are on duty. Given the nature of police work, the appropriate standard is to have no alcohol or recreational drugs in one's system when on duty.

Recommendation P.3

CONSUMPTION OF ALCOHOL AND RECREATIONAL DRUGS

The Commission recommends that

The RCMP should amend its *Code of Conduct* to state clearly that members must have no alcohol or recreational drugs in their system while on duty, and that they must not report for duty or self-deploy if they have consumed alcohol or recreational drugs.

When he joined the critical incident response by radio, Sgt. O'Brien failed to state that he was not acting as supervisor or to clarify that he was not on scene. This information was important for responding members in terms of their understanding of the command status. For example, in her Commission interview, Cpl. Natasha Jamieson explained in reply to a question about who was responsible for setting up containment:

> [P]rior to me even getting there [to Portapique], there was Sgt. O'Brien and the Risk Manager involved. So, I couldn't tell you. And I know that members were coming … like where [Cst.] Vicki [Colford] and I were, like, once we weren't going in as an additional team, our role there or even kind of in amidst while that thought process is happening, is the

> containment of that area [at the top of Portapique Beach Road], no vehicles getting in and checking all the vehicles getting out.[90]

S/Sgt. Carroll, who was then the district commander for Colchester County, testified that when first alerted to the ongoing incident in Portapique, he went to the Bible Hill detachment with the intention of attending the scene to provide "supervision and some guidance, some help to the members on scene."[91] However, when he arrived at the detachment, he was diverted from this plan and instead remained there to complete tasks assigned by Acting Insp. Halliday, who was senior to him within the RCMP's command structure. Misunderstandings arose with respect to these assignments of responsibility. S/Sgt. Halliday testified that he was not aware that Sgt. O'Brien was working from home until sometime after he arrived at the Bible Hill detachment (after 11:38 pm). Notes taken by scribe Sgt. Robert (Rob) Lewis for the en route critical incident commander S/Sgt. West suggest that at approximately midnight, these members understood that S/Sgt. Carroll was on scene at Portapique.

The records of radio transmissions from the first three hours of the critical incident response show that RM Rehill coordinated much of the initial response, including matters such as the positioning of general duty members to establish a perimeter and containment of the active scene. Travel time and the accessibility of additional resources for a critical incident response are key factors in a rural critical incident response such as the one in Portapique. The number of members available to provide perimeter and containment increased over time, as members from further afield travelled toward Portapique to assist with the response. At times, other non-commissioned officers, including Sgt. O'Brien and S/Sgt. Carroll, weighed in by radio on this task. However, the command group who based themselves at the Bible Hill detachment were not an effective substitute for a scene commander, who would have been better placed to make timely decisions about placement of members and how best to task members as they arrived on scene. In short, the lack of a scene commander gave rise to shortcomings in response coordination. These shortcomings are well illustrated by a discussion of the confusion that arose with respect to the eastern perimeter of the initial containment efforts outside Portapique. As the discussion below also illustrates, the lack of a scene commander to establish and assess containment measures also increased the burden on RM Rehill.

Between 10:04 pm and 10:35 pm on April 18, 2020, RCMP activities included having first responding members travel from the Bible Hill detachment to Portapique,

building situational awareness, and seeking more information about possible perpetrators and the growing number of reported shootings and fires. By 10:32 pm, all four of the on-duty Bible Hill members had arrived at the initial meeting area on Portapique Beach Road between Highway 2 and Orchard Beach Drive. Thereafter, Cst. Colford remained in this area, while Acting Cpl. Beselt, Cst. Merchant, and Cst. Patton entered Portapique and initiated the IARD response. Over the ensuing 30 minutes, radio traffic became congested as the IARD responders reported their observations, Cst. Colford conveyed information from witnesses and provided updates from the scene, approaching members sought directions and information about where to position themselves, dispatch conveyed information from the Operational Communications Centre, and Sgt. O'Brien reminded responding members to follow safety protocols. Between around 10:35 pm and 10:42 pm, RM Rehill was not monitoring the radio because he was briefing Acting Insp. Halliday by phone. At other times, he was pulled away from the radio to speak with 911 callers, other non-commissioned officers, and Operational Communications Centre employees.

At 10:43 pm, RM Rehill confirmed by radio that the Emergency Response Team and the critical incident commander were being activated. At 10:44 pm, he turned his attention to perimeter control and containment on Highway 2. Members from the Millbrook and Parrsboro detachments had indicated they were approaching Portapique.[92] These members would have been coming from the east and west, respectively, along Highway 2. At 10:44:25 pm, RM Rehill instructed Cst. Christopher (Chris) Grund, who was driving from Millbrook, to seal off Highway 2 before Portapique (east of Portapique) "so we can isolate the scene a bit."[93] Cst. Grund responded, "10-4 [Affirmative], I'm on my way there."[94] At 10:44:49 pm, RM Rehill suggested that Hillview Lane, which lies approximately 4 kilometres east of Portapique toward Great Village, "might be a good spot to seal it off – don't want any traffic in there."[95] At this time, Cst. Grund was passing through Lower Debert. However, at about the same time, Cst. Jordan Carroll and Cst. Jeff Campbell were also radioing that they were approaching Portapique from the west, and there was evidently confusion about to whom of these responding members RM Rehill was directing his instruction.

At 10:48:41 pm, Cst. Colford broadcast via Colchester radio: "[Millbrook], if you guys want to have a look at the 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." Cst. Colford had driven to Portapique from Bible Hill, and her reference to "before here" meant east of Portapique. She was, at this time, speaking to the MacDonalds,

and Ms. MacDonald had provided this information. RCMP members who were monitoring the radio at that time advised the Commission that they did not recall hearing Cst. Colford's statement. However, RM Rehill explained in his testimony: "[I]f you look at the time … Grund is en route at that time … when she says it. And I already have him in my mind going to Hillview Lane. So I understood we had it covered off once he got there and stopped."[96] RM Rehill's recollection and understanding are supported by a containment map that was produced by S/Sgt. Carroll, which showed Cst. Grund positioned on Highway 2 east of Clarke Road, near Highland Village.

In Volume 2, What Happened, we detailed our conclusion that the perpetrator left Portapique via the track through the woods that local residents call the "blueberry field road," east of Portapique, at approximately 10:45 pm on April 18 and travelled either via Brown Loop or (less likely) Clark Road to Highway 2, before driving east along Highway 2 to Great Village. The perpetrator's replica RCMP cruiser was captured by the security camera at Wilson's Gas Bar in Great Village at approximately 10: 51 pm.

GPS records establish that Cst. Grund passed through Great Village between 10:47 pm and 10:50 pm on April 18, stopped on Highway 2 approximately 250 metres east of Hillview Lane between 10:52 pm and 10:55 pm, and then carried on to Portapique Beach Road, where he arrived at approximately 10: 58 pm. At 10:59:10 pm, Cst. Grund radioed "GRUND's on scene here. If you guys need me to go anywhere let me know. I'm here with [Cst.] Vicki [Colford]."[97] In his Commission interview, Cst. Grund explained that when he arrived at Portapique Beach Road, he was the fourth RCMP member in that location. At this time, he sought cover and "was waiting, in essence, at that point to do whatever they needed me to do."[98] Had a scene commander been put in place at Portapique, this individual would have noticed that Cst. Grund and other members were there and awaiting assignments.

At the time when the perpetrator must have been driving east on Highway 2 between Clark Road and Great Village, Cst. Grund was driving west between Great Village and Hillview Lane. He would not yet have been in a position to establish containment at Hillview Lane. However, it is highly probable that he passed the perpetrator travelling in the opposite direction, most likely on Highway 2 west of Great Village.

In his interview with the Commission, Cst. Grund stated that he did not see a police vehicle driving west along Highway 2 as he headed toward Portapique. He did not recall receiving a direction from the risk manager about where to position himself

or Cst. Colford's transmission about a possible alternative way out of Portapique. He also described his unfamiliarity with the Portapique and Great Village area and said his focus had been split several ways: navigating, preparing hard body armour and his carbine, attempting to speak by cellphone to his Millbrook colleague Cpl. Jamieson, and seeking to arrive as rapidly as possible. Other general duty members – for example, Cpl. Jamieson and Cst. Paul Cheeseman, who arrived at Portapique at around the same time – similarly described a degree of uncertainty about roles, responsibilities, and where to establish containment.

In his testimony, RM Rehill confirmed that, on the basis of their earlier exchange, he understood that Cst. Grund had established containment at Hillview Lane. Had this been so, Highway 2 east of Portapique, including Brown Loop and Clark Road, would have been effectively contained by approximately 10:52 pm on April 18, 2020.[99] By this time, however, the perpetrator had already passed through Great Village. In any event, no containment was established east of Portapique Beach Road until approximately midnight.

Our purpose in explaining this incident in some detail is to illustrate that, in the absence of a scene commander, the general duty members who attended Portapique and the risk manager who was based in Truro had difficulty keeping track of the overall positions of responding members. We found no basis to conclude that Cst. Grund deliberately ignored RM Rehill's direction; rather, the evidence suggests that he may not have been aware of that direction. As we explain further below, we also conclude that RM Rehill was significantly overburdened in his role as risk manager. He did not recognize that the eastern perimeter had not been established because he was overtasked, and there was no scene commander to ensure that his directions were followed. If he had been supported by a properly trained and equipped scene commander with timely access to information and good communications connectivity, this gap would probably not have arisen.

According to the RCMP's IARD policy, the scene commander is responsible, among other things, for establishing an outer perimeter. Ret'd. A/Commr. MacNeil emphasized the importance of front-line supervision for situational awareness and of maintaining an "overall view of where resources [are] positioned."[100] He found that the absence of effective on-scene supervision adversely affected the RCMP response in Moncton in 2014. Members of the Commission's roundtable on June 1, 2022, similarly emphasized the importance of having an on-site commander. S/Sgt. Carroll testified that "not being on scene made it hard to do the exact placement" of RCMP members who were providing containment on scene.[101]

Nonetheless, and despite the fact that they were evaluating resources available to the critical incident response, the command group at the Bible Hill detachment did not recognize the need for a supervisor to attend the scene once Acting Insp. Halliday told S/Sgt. Carroll to remain at Bible Hill and not go to Portapique himself. The failure to send a non-commissioned officer to supervise the scene had an adverse impact on the coordination of RCMP resources, including members in Portapique. It also exacerbated the burden on RCMP members at the scene, who were left without a properly trained supervisor to direct them in a highly complex and dangerous environment. We agree with Ret'd. A/Commr. MacNeil that remote supervision cannot substitute for a scene commander.

When appropriately trained and equipped scene commanders are present, they can be expected to conduct or direct a certain amount of on-site evaluation to identify the best positions for containment, to monitor members who are holding the perimeter, and to recognize when members are not in their assigned position. This approach will help the Emergency Response Team and the critical incident commander when they arrive on scene or assume command. Assigning a scene commander also makes it more likely that matters such as the identification of witnesses will be captured for the benefit of subsequent investigation, including follow-up during a prolonged critical incident response. In the early stages of the RCMP response in Portapique, the absence of a scene commander meant that crucial opportunities to organize the perimeter, gather situational awareness, and identify opportunities for investigation were lost.

Furthermore, the lack of scene command and the associated failure to gather an understanding of the Portapique area terrain outside the hot zone contributed to the erroneous belief that the perpetrator could not have left Portapique by any route other than Portapique Beach Road or via Five Houses – an idea that influenced the RCMP's actions and decision-making throughout the night of April 18/19, 2020. We will return to this aspect of the decision-making in Chapter 3.

Initial Command of the Critical Incident Response

The Commission heard a great deal of evidence about the command structure in place before the critical incident commander formally assumed command at 1:19 am on April 19, 2020. RCMP policy makes it clear that from that time forward, S/Sgt. Jeff West had "overall command and control of the critical incident," including "all related resources."[102] RCMP policy manuals do not, however, state who holds overall command before the critical incident commander assumes command. Rather, they assign certain responsibilities to the scene commander and others to the risk manager and the Operational Communications Centre.

The Attorney General of Canada submitted to us that "the command structure was clearly defined and established in accordance to RCMP policy and training."[103] It further suggested that "the transcripts and evidence of the members who formed part of the command structure reveal that all were clearly aware of the structure, and their roles and individual responsibilities therein."[104] We agree that having clear policies with respect to interim command is important, but we do not accept the submission that roles and responsibilities were clearly set out in the applicable policies or were apparent to everyone involved in the RCMP response to the mass casualty.

In particular, the Attorney General of Canada submitted:

> Policies and training within the RCMP inform members that the risk manager will remain in a supervisory function for the on scene commander pending the arrival of a senior member of the impacted district. Once that senior member is operational, he/she assumes responsibility of the ongoing incident until the critical incident commander takes over control. The risk manager remains available to offer support to the district commander in responding to the ongoing incident.[105]

The Attorney General of Canada suggested, accordingly, that "Acting Insp. Halliday was the senior member and he assumed the role of interim Incident Commander, taking over from the Risk Manager until the Critical Incident Commander took over."[106] This submission is contradicted by the evidence, set out below, that both Acting Insp. Halliday and RM Rehill regarded RM Rehill as the ad hoc commander of the critical incident response after Acting Insp. Halliday was engaged. As we describe in this section, the other individuals who were involved in the RCMP's

critical incident response varied in their understanding of who held interim command after Acting Insp. Halliday became involved.

The roles and responsibilities of risk managers are not set out in official RCMP policy manuals. Accordingly, we have looked to other internal documents produced by the RCMP and to the testimony of RCMP members to understand that role. A 2017 RCMP document titled "H Division OCC Risk Manager Roles and Responsibilities" explains:

> Risk managers are trained incident commanders so in cases where immediate control needs to be provided (e.g. in high risk situations), they will provide it until such time as local supervisors can arrive on scene and take charge of the situation.[107]

Specifically to critical incidents, this document states that risk managers will "[c]o-ordinate high risk incidents and manage all the resources, regardless of where they come from, until Incident Commanders can take control of the situation on site."[108] This responsibility also extends to liaising directly with support services such as the Emergency Response Team and members of the Police Dog Service.

As H Division's officer in charge of operational support and communications centre, Insp. Dustine Rodier had responsibility for the Operational Communications Centre, including risk managers.[109] (She has since been promoted to the rank of superintendent.) A document she prepared after the mass casualty in September 2021 explains:

> In the event of any high-risk emergencies such as shootings in progress … the Risk Manager will immediately take command and control over the situation, deploy resources and direct the response. They will also call in and/or re-deploy resources to allow for an increased response, while ensuring continued service delivery for the rest of the Division.
>
> … Risk Managers will continue to maintain control over a situation until the incident either comes to an end or the CIC [Critical Incident Commander] takes over from them. When CIC does take over command, the Risk Manager will transition to a key, direct support role to the CIC, coordinating, supplementing and directing front line resources as needed. As a result, Risk Managers work very closely with the CIP [Critical Incident Package] on a regular basis and have to be well versed in CIP communications and operations.[110]

In our roundtables, those with expertise in critical incident response in major metropolitan areas in Canada explained the standard flow of command. In the words of one roundtable member:

> [N]ormally, in the initial stages of an emergency response like this, it's the road sergeant. And then as the event grows, it becomes the duty inspector, and then, of course, the command will appoint a incident commander, and they'll have an on-site incident commander, and they will also more than likely stand up our Major Incident Command Centre, which will also have an incident commander in it.[111]

In the particular context of the mass casualty of April 18 and 19, 2020, Finland provides a helpful point of comparison because, like Portapique and parts of Canada, it is, predominantly, rural, sparsely populated, and heavily forested. We heard from the former rector of the Finnish University Police College, Dr. Kimmo Himberg, that in this jurisdiction, larger-scale critical incident response will initially be led by a field sergeant, but if "it escalates further, or if it's an even larger, even broader incident, then the leadership responsibility is transferred to a command centre."[112] Rector Himberg explained that Finland maintains a small number of fixed command centres with "a highly developed computer and communication system, so that the commanding officer has a lot of information available."[113] In a large-scale incident, a senior police officer assumes command from this centre, and the field sergeant remains on site as scene commander.

Although the Toronto Police Service and the Finnish Police Service each use slightly different terminology from the RCMP (and from one another) for supervisory roles, both follow essentially the same command structure as set out in the RCMP's IARD policy: that is, command is initially taken by one of the more experienced general duty members in the initial response. When a more senior officer attends the scene, command will be transferred to that person until a critical incident commander takes command.

We agree with the authors of the 2015 *C3 – Command, Control and Communications Guide* that **"somebody must be in charge, everybody must know who is, information must flow back and forth in a crisis and the police response must be structured and controlled by a central point."**

MAIN FINDING

We conclude that S/Sgt. Brian Rehill acted as ad hoc critical incident commander until S/Sgt. Jeff West assumed control at 1:19 am on April 19, 2020. However, we find that there was confusion about the command structure and about who among the RCMP members were performing specific roles and responsibilities in this interim period. We also find that this confusion detrimentally affected the critical incident response, most notably with respect to the lack of an assigned on-scene supervisor to exercise scene command.

The fact that the question of who held command persisted throughout the Commission proceedings suggests that the RCMP's policies, procedures, and command structures are unclear even within the organization. These questions received considerable attention in public proceedings and Participant submissions. Given that we have concluded that command, roles, and responsibilities were not clear, we recount the evidence we heard on this point in some detail before considering a few of the challenges that arose with respect to overall command and coordination.

On the evening of April 18, 2020, the question directly arose at times about who was in command of the critical incident response. When the initial responding members were driving toward Portapique, Acting Cpl. Beselt queried whether RM Rehill was monitoring the call. He received an affirmative reply. At 11:45 pm, the following exchange occurred on Colchester radio:

> CST. [BILL] NEIL: I don't know who's got the Command.
>
> S/SGT. CARROLL: Staff REHILL has Command, folks – Staff REHILL has Command.
>
> CST. NEIL: Staff REHILL from NEIL we've got five members down at the end of Portapique um, Beach road, at number 2. Give us something to do.[114]

These appear to be the only times that the officer in command was stated by radio before CIC West's broadcast at 1:23 am on April 19 that he had assumed command. (As we explained in Volume 2, CIC West took command at 1:19 am on April 19 but was not able to broadcast it until 1:23 am.)

Other non-commissioned officers also issued direction, provided information, or made requests by radio. For example, after he self-deployed, Sgt. O'Brien broadcast the perpetrator's two Portapique addresses via Colchester radio. From 10:47 pm on April 18, he issued directions to and sought information from the IARD responders and also broadcast instructions to other members on scene. Thereafter, he issued many directions by radio. As the operations non-commissioned officer for Bible Hill, Sgt. O'Brien was, in normal circumstances, the direct supervisor of many of the responding members, including those in the IARD response. His directions likely carried the force of his supervisory role during the critical incident response, despite the fact that he was not on scene and had not been scheduled to work that night. Although the Attorney General of Canada stated in its submission that Sgt. O'Brien "was not part of the command structure,"[115] we note that he was issuing directions to members on scene (e.g., about safety measures) and that both responding members and members of the command group regarded his role as supervisory. Acting Insp. Halliday testified that he "spoke directly with Sergeant O'Brien … at one point to make sure information was getting relayed to the members in terms of their immediate action response."[116]

S/Sgt. Carroll was the Colchester district commander to whom Sgt. O'Brien reported. At 11:00 pm, S/Sgt. Carroll announced he was on air and soon thereafter intervened in the containment arrangements west of Portapique. His intervention related to the fact that a single member – his son, Cst. Jordan Carroll – was located on Highway 2 near Five Houses. A short time earlier, Cst. Carroll had reported by radio that he could see a car's headlights, stationary, on Five Houses Road from his position on Highway 2 west of Portapique. Cst. Jeff Campbell had responded, "Jordan, I copy that. I think I'm coming up on ya, just passing Brown Rd."[117] Cst. Campbell followed up at 11:01 pm to confirm Cst. Carroll's position and advise that he was coming along Highway 2. Soon after, having confirmed that Cst. Colford had another member with her at Portapique Beach Road, S/Sgt. Carroll expressed concern about Cst. Carroll's situation:

> 11:01:36 – S/Sgt. CARROLL: … I'm concerned about a vehicle sitting there at Five Islands Road with just – with his headlights on. And we've got a single member up there dealing with that.[118]

RM Rehill responded to S/Sgt. Carroll:

> 11:01:58 – RM REHILL: Staff CARROLL from REHILL, [unit] 01-Bravo-02 is moving in there, he should join up with [unit] 29-Bravo-01. Looking at the map, I think, if that's our suspect he looped around to try to come out there but Jordan's in his way.
>
> ...
>
> 11:02:11 – S/Sgt. CARROLL: OK. Well, let's get some backup up there if we can guys.[119]

Cst. Campbell responded to S/Sgt. Carroll at 11:02:34: "Yeah, 10-4 [Affirmative] Staff Carroll, I am bootin' it. I am almost there."[120]

S/Sgt. Carroll's dispatch caused the IARD responders to query Cst. Carroll's position relative to their location on Orchard Beach Road in Portapique:

> 11:02:15 – Cst. PATTON: Where are we in reference to Constable CARROLL? We're still at that red house with the kids ...
>
> 11:02:29 – Cst. PATTON: Where are we in reference to Constable CARROLL? We're still at the red house.[121]

Cst. Patton did not receive a reply to this question, despite asking twice. This silence was a significant oversight on the part of those coordinating the response because the IARD responders were on foot in unfamiliar terrain, without mapping technology. While the headlights seen by Cst. Carroll turned out to be innocent, and Five Houses Road was some distance from Orchard Beach Road, any plausible information about the perpetrator's location relative to the IARD responders' location should have been conveyed to the IARD responders as a high priority.

S/Sgt. Carroll was understandably concerned about the safety of his son, Cst. Carroll. When he related his memory of this moment in an interview and in testimony, he recalled (incorrectly) that "nobody's answering" Cst. Carroll when he radioed about his observations.[122] In fact, Cst. Carroll's observations had been noted, and back-up was responding to his location. At the time S/Sgt. Carroll joined the radio conversation, a great deal was happening elsewhere. The IARD responders were outside the McCully home and had just seen a person with a flashlight in the woods (later proved to be Clinton Ellison, but at the time the IARD responders considered it could be the perpetrator). Cst. Colford and Cpl. Jamieson were speaking with the MacDonalds near the corner of Portapique Beach Road and Highway 2. RCMP

members were responding from detachments in several directions, and RM Rehill was directing containment.

S/Sgt. Carroll did not have overall situational awareness with respect to these many pieces of the response. He had no access to CIIDS, so could not see the location of members who had already been positioned for containment. Both on the night of April 18, 2020, and in testimony, he referred to "Five Islands Road" instead of "Five Houses Road." Five Islands is a provincial park some distance west of Five Houses. S/Sgt. Carroll testified that he would have intervened in the same way with respect to any member who was requesting back-up and not receiving a response. However, his intervention was unnecessary given that back-up was already en route. In light of the complex overall picture of the response at that time, S/Sgt. Carroll's intervention distracted responding members and the risk manager from other high-priority tasks and also had the potential to cause confusion as to the command structure.

National RCMP policy regarding conflict of interest directs employees to "avoid … directly supervising members of your family … in order to avoid a conflict of interest."[123] On April 18 and 19, 2020, S/Sgt. Al Carroll and his son Cst. Jordan Carroll were placed on the same critical incident response despite normally working in separate counties. S/Sgt. Carroll testified with respect to his intervention by radio that "it wouldn't have mattered if it was my son or not. I would have had the same response to any of the members out there."[124] However, his intervention attended to Cst. Carroll's request without paying full regard to the range of other things happening at that time or to the fact that other officers were directing overall resources including back-up for Cst. Carroll. In general terms, a supervisor should refrain from intervening directly in the task of directing resources when that task is being performed by others. We acknowledge that many people may unconsciously pay particular attention to the safety of a family member in a dangerous situation, and it is a short step from monitoring to intervening where that safety may be threatened. This example demonstrates the good sense inherent in the RCMP policy that members should not supervise their own family members. In future, supervisors must scrupulously refrain from giving orders or intervening in any way that may be perceived as favouring a family member. We make recommendations about RCMP radio protocol in Chapter 3 of this volume.

In her Commission interview, Cpl. Jamieson reflected on the fluidity of RCMP supervision at this stage in the critical incident response:

> COMMISSION INVESTIGATOR: Do you feel that there was enough control of the situation, from management, from whoever was in charge?
>
> CPL. NATASHA JAMIESON: Um, I feel that it was a very fluid situation. Ah, myself, with regards to my thought process and what was kind of going on from the information that's coming in was like in my mind, you know how you have a kind of mental chaos like you're gathering everything. But I was fairly clear on what the initial member and members on scene were re … were relaying. There was a time where there were two or three Commanders or per se on the air at different times, so … but I do know that there was direction at one point that Rehill was in command, and I do know that I recall having heard Jeff West come and say he was in command. So, there was those transitions had happened. Yeah, that's kind of all I can speak to.[125]

It is apparent from these examples that several non-commissioned officers were issuing direction about the critical incident response in the first few hours of the response in Portapique on April 18, 2020. Except on the occasion when Cst. William (Bill) Neil sought clarification of the command structure, these officers did not state the capacity in which they were issuing instructions or confirm who held overall command of the initial response.

LESSON LEARNED

It is essential for responding officers to know who has command of a critical incident response. Policies should clearly assign this role, at all stages of the critical incident response. Information about who has command, and other information about supervisory roles and responsibilities, should be shared regularly with responding members during a critical incident response. Other supervisors must refrain from giving directions to responding members.

Recommendation P.4

SUPERVISION DURING A CRITICAL INCIDENT RESPONSE

The Commission recommends that

(a) The RCMP should amend its policy to identify which non-commissioned officer will attend the scene of a critical incident response. This person must attend as soon as possible.

(b) During a critical incident response, the name and rank of the person who holds command and the name and rank of the scene commander should be recorded in the incident log and broadcast frequently by radio.

(c) Supervisors who have not been tasked with commanding the response should refrain from giving direction to responding members.

Commission interviews and testimony demonstrate that those non-commissioned officers who were involved in the critical incident response understood the delineation of roles and responsibilities somewhat differently from one another. Perhaps most important, both Acting Insp. Halliday and RM Rehill testified that RM Rehill retained ad hoc command after Acting Insp. Halliday was engaged in the incident and until the critical incident commander took command. Overall, of six non-commissioned officers who were involved in the response and gave evidence on this point, only two (Sgt. O'Brien and S/Sgt. West) testified that a senior member of the Colchester District had taken command from RM Rehill. Given that these non-commissioned officers had differing understandings of their respective roles and responsibilities, it is reasonable to conclude that responding members were similarly uncertain.

RM Rehill first spoke to Acting Insp. Halliday at 10:35 pm on April 18, 2020. Acting Insp. Halliday arrived at the Bible Hill detachment at approximately 11: 38 pm. S/Sgt. Rehill testified that at 11:00 pm, he considered himself to be the ad hoc commander in charge of the response. He confirmed in his testimony that at 12:23 am, he retained command of the critical incident response because the critical incident commander and the associated command structure was "not officially up and running yet."[126] He also explained that when S/Sgt. West broadcast that he was taking

command of the critical incident response, that broadcast was significant because "at this point, I'm going to step back, and I still play an assistance role."[127]

For his part, Acting Insp. Halliday explained in his Commission interview that when he arrived at the Bible Hill detachment:

> [RM Rehill was] for all intents and purposes, the ad hoc Incident Commander, which he would have been for, you know, some time, some period of time up to that point … I decided to leave Brian in that role, allow him to control those resources so that I could focus on … on the big picture.[128]

Acting Insp. Halliday explained that he was, from the time he arrived at the Bible Hill detachment, "in charge of the overall operation, what's taking place."[129] When he testified, he was asked to clarify this delineation of responsibilities. He responded:

> So when the call initially comes in and [RM] Brian [Rehill] starts controlling the resources, he would be the ad hoc incident commander at that time. And he is controlling who is going where, who is doing what, and coordinating that response.
>
> By virtue of my position as the acting operations officer and the senior member on the ground as a uniformed personnel, I would be the person who has overarching responsibility for everything that's going on. So my role would be to have an understanding of what's taking place and ensuring that people are in roles carrying out their duties in a manner that supports, you know, the success of the operation. And in this case, given the fact that Brian had been – had, you know, the best situational awareness of anyone, really, in regards to the information that had already been coming in, who was on the ground, where they were, what they were dealing with, to me it made perfect sense for him to maintain the continuity over that at that time.[130]

Acting Insp. Halliday later confirmed that he considered S/Sgt. Rehill to be "[i]n charge of managing the response to the situation"[131] and that, to him, "it was clear who was in charge of controlling the resources at that particular time, and I think it was clear who was doing what and what their responsibilities were."[132] When asked about his role in the period before S/Sgt. West took command, Acting Insp. Halliday testified that his responsibilities were as follows:

> [M]aking sure that, you know, all of the tasks that needed to be required in anticipation of the CIC were getting done. So, everything from, you know, looking at a helicopter, making sure that a profile was being done, making sure that we had sufficient resources on the ground to deal with the containment piece that was there, sourcing other equipment that might be required by the members, so maps, those kinds of things, calling out the Major Crime Team. So all of those other things that take time on phone calls and updating, you know, people about what's taking place, and securing other assets fell to me, so that those folks that were currently engaged at the operational level at the event could focus on that.[133]

S/Sgt. Carroll suggested that at around 11:00 pm on April 18, he, Acting Insp. Halliday, and S/Sgt. Allan (Addie) MacCallum "made the directive that Sergeant – Staff Rehill would take over placement of members until the command structure got on scene and then we would be looking at it more closely."[134] In response to a follow-up question about who was in charge of containment at that time, S/Sgt. Carroll replied, "I'd say it was like, we're working together."[135] Later in his testimony, he further clarified, in reference to Cst. Neil's 11:45 pm query about the command structure:

> S/SGT. ALLAN CARROLL: I thought it was earlier that we made it clear that Staff Sergeant Rehill was taking charge and placing people and telling people what to do until such a point as the Command Group was out at the firehall.
>
> COMMISSION COUNSEL: Right. And it's clear that the command group you're referring to, MacCallum, Halliday, and Carroll, were not at the Command Post at this point?
>
> S/SGT. ALLAN CARROLL: No, that is correct.[136]

S/Sgt. MacCallum testified that RM Rehill "had taken on the ad hoc command role for the contact team and the inner perimeter and how to deal with the threat."[137] He also suggested that "We [Acting Insp. Halliday, S/Sgt. MacCallum, and S/Sgt. Carroll] had a command post temporarily at the Bible Hill Detachment."[138]

In response to a question about the command structure overnight in Portapique, Sgt. O'Brien testified:

> I perceived Staff Sergeant Steve Halliday to be the one in charge. Given my understanding of the risk manager's functions and roles, once Staff Sergeant Al Carroll took over management of the scene, he would have been in charge. And then when [Acting Insp.] Steve Halliday, who was his direct report or his superior, came on the air or entered the scenario, he would have been in charge.[139]

S/Sgt. West, the critical incident commander, testified that he believed it was "the risk manager working in conjunction with the person on the ground, who I believe that Acting Cpl. Beselt was the on scene commander, for lack of a better term, and the senior member" who was in command and control of the critical incident response before he assumed command.[140] However, he rejected the suggestion that RM Rehill was a "temporary Critical Incident Commander":

> Staff Rehill is helping control the initial critical incident response. He's not a Critical Incident Commander in the sense of training, skillset that goes with it. So he's working as – and I believe [S/Sgt.] Kevin [Surette] referenced it early on this morning, talking about the Initial Critical Commander course. It's a one-week course that I believe all risk managers, even when I was in the OCC, the risk managers take it, and most senior NCOs, and most uniform members in this division have taken that course.
>
> ... whether it's the Risk Manager or whoever the senior NCO that's taking charge, they're controlling their resources, their initial Critical Incident Response to this matter.[141]

Neither S/Sgt. Carroll nor Acting Insp. Halliday testified that they had assumed command from RM Rehill. Indeed, at 11:45 pm on April 18, S/Sgt. Carroll confirmed that RM Rehill had command of the response.

Based on this and other evidence, we have concluded that RM Rehill retained command of the initial critical incident until he was relieved of that responsibility by CIC West. Other non-commissioned officers were performing a range of tasks that may best be understood as being directed towards finding resources, including personnel, supporting RM Rehill, and preparing for the arrival of the critical incident commander. We consider these activities in more detail in Chapter 3.

In his testimony, RM Rehill reflected that, with the benefit of hindsight:

> [O]nce the District Commander for that district is up and running, and he has, say, MacCallum and Halliday and them all there with him, collaborating together in Bible Hill, maybe that's at the point where they should say, "We have this." Because they also had Jeff West coming on the radio while he's on route. So now you have West, you have MacCallum, you have Halliday, you have Carroll, O'Brien. So, at that point, maybe it's time for us [risk managers] to stand back right away and take a – even though they don't have their official CIC up and rolling, let them take the ball from there and let us fall back into an assistance role. I think that's certainly worth looking at. Or if it's just going to be me, then you have to have radio silence from all those guys, but they have such valuable input, I don't know if that's the right way to go. And sometimes they knew I was so darn busy, they decided to voice to the members directly instead of trying to call me. So there's so many ways we can look at that. But we do need to get something clear and concise for the future.[142]

We agree with RM Rehill that RCMP policy with respect to command structure requires clarification. The relevant policies should be redrafted to be far clearer about the transition of command as a critical incident response scales up, particularly with respect to the period before a critical incident commander assumes command. Given that the risk manager's responsibilities, including responding to calls unrelated to the critical incident, we do not consider that ad hoc command should be situated with the risk manager in future. Rather, a scene commander must be nominated immediately, and an operational supervisor should be assigned to attend the scene as soon as feasible. Overall command should be situated within the line of general duty command. Depending on the scale and the duration of a critical incident response, and the experience of the relevant members in the chain of command, this commander may, initially, be the operational non-commissioned officer for the district. However, for a response of the scale of this mass casualty, command should be transitioned to an experienced senior non-commissioned officer as soon as possible. This member will require appropriate training and access to all relevant resources – for example, technology that tracks the location of responding members. On this model, the risk manager would retain responsibilities associated with the Operational Communications Centre, including managing other police activities while the critical incident response continues.

Recommendation P.5

ROLES AND RESPONSIBILITIES DURING A CRITICAL INCIDENT RESPONSE

The Commission recommends that

RCMP policies should be amended to make roles and responsibilities during a critical incident response clearer. In the period before a critical incident commander assumes command, ad hoc command of the response should be situated with a suitably experienced, properly trained, and appropriately resourced supervisor within the district command structure.

Training and Preparedness for Initial Command

The MacNeil Report made specific recommendations about how supervisors should be trained for the roles they play in critical incident response. In this section, we review the RCMP's efforts to implement this recommendation. We find that many of the supervisors involved in the initial critical incident response in Portapique had not received the training that Ret'd. A/Commr. Alphonse MacNeil recommended, despite the RCMP's evidence that this training is mandatory. We also evaluate the adequacy of mandatory training designed in response to the report's recommendations.

The MacNeil Report recommended that the RCMP "examine how it trains front-line supervisors to exercise command and control during critical incidents" and "provide training to better prepare supervisors to manage and supervise throughout a critical incident until a [critical incident commander] assumes control."[143] According to an affidavit provided to the Commission by RCMP Insp. Pharanae Croisetiere and dated August 11, 2022, these recommendations have been implemented. Insp. Croisetiere is the officer in charge of operational policy and compliance within the

National Criminal Operations Branch of RCMP Contract and Indigenous Policing. The affidavit explains how these recommendations were implemented:

> To ensure that frontline supervisors utilize the basic principles of command and control during critical incidents the following tools were developed.
>
> - In July 2015, a Quick Reference Guide and Scenarios were completed and distributed to the Divisions.
> - In July 2018, the on-line course Initial Critical Incident Response (ICIR) 100 was made available to all members[.] It is mandatory for all frontline supervisors.[144]

The affidavit also states that "an additional course, ICIR 200 was also introduced."[145] A copy of the quick reference guide was provided to the Commission. It consists of a one-page checklist of the steps the initial commander should take or delegate to others.

The quick reference guide helpfully sets out a number of matters for the initial incident commander to address. For example, it ensures that the initial commander should announce that he or she has command and also describe the kind of threat being faced. It directs this commander to ensure that members have the necessary equipment, to request resources as needed, and to consider containment. It suggests the importance of establishing a staging area for arriving members and other emergency services. While providing a helpful checklist, it by no means addresses the entirety of the task that presents itself to an initial commander who holds command and control of a complex critical incident response for several hours. This guide is reproduced on the next page.

The RCMP's "learning product standard" for the ICIR level 100 course describes it as a 90-minute online course that will "provide regular members with the knowledge to effectively take command and control of a critical incident."[146] It is a "self-directed and self-paced" course that is assessed through a final examination in the format of multiple-choice questions.[147] Candidates have a maximum of four attempts to pass the final exam. From the sparse description of the course content, it appears to be oriented toward equipping members to take command on scene. In an interview with the Commission, Supt. Phil Lue, the RCMP's former director of the critical incident program, questioned the value of an online course for teaching complex tactical subjects such as initial incident command, as compared with the tabletop exercises that may be used in classroom-based training:

I don't think anything can replace that – the tabletop that we actually do and we teach. So, we have maps and we basically give people a scenario and we read injects as they go, and they have to write stuff on a map and say that I'm going to – hey, I'm going to get my – this is where I'm going to set up my containment, this is where I'm going to do this. And it's actually tactile that they actually do it because that's what you would do in real life; I think there's far more benefit to that. Um, when you take – when you take something online, there's no real kind of pressure or stress ... hey, I'm going to take this online course. I have a coffee, I'm just going to – you know, this is one of the like 300 online courses I have to complete.[148]

RCMP Initial Critical Incident Response Quick Reference Guide

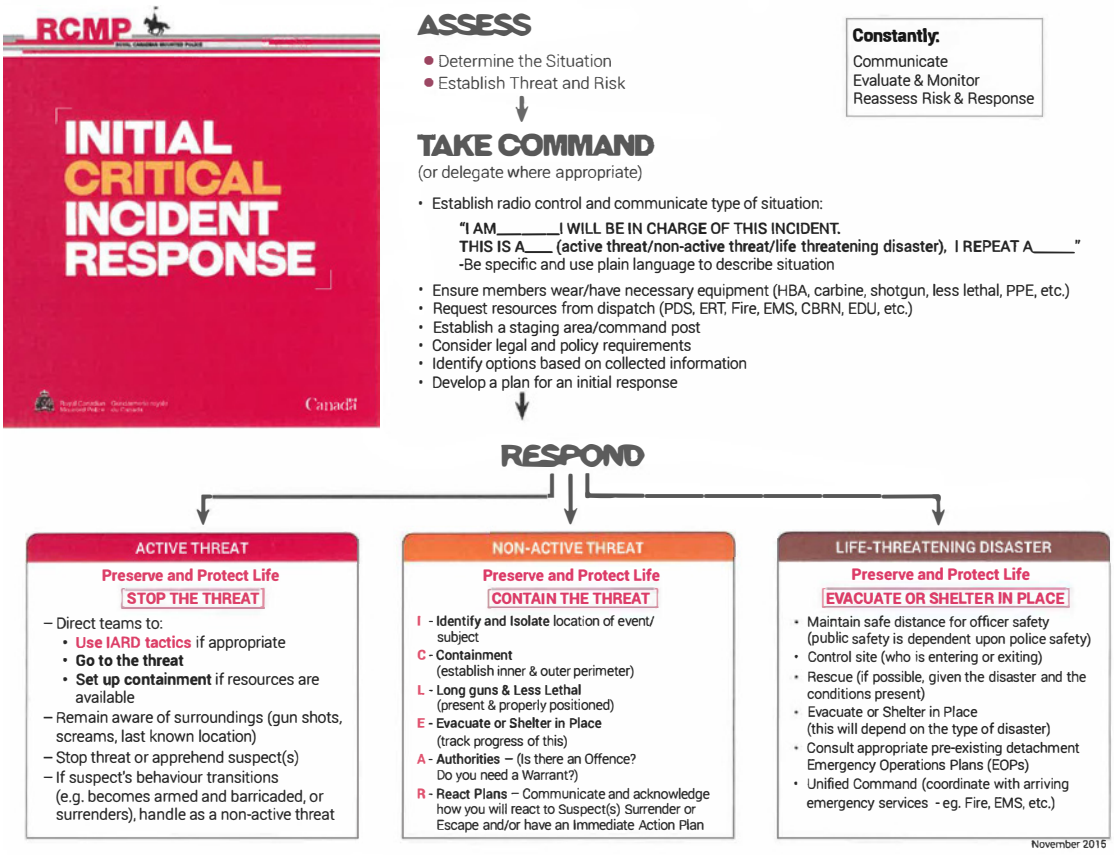


Exhibit "E" of Affidavit and Supporting Materials of Pharanae Croistiere: COMM0062461 at p.44.

Given the complexity of the decision-making and resource management that RM Rehill faced in the first three-and-a-half hours of the critical incident response in Portapique, it is clear that a 90-minute online course is inadequate to prepare supervisors for initial command of a complex critical incident. The online ICIR level 100 course is not an adequate response to Ret'd. A/Commr. MacNeil's recommendation that front-line supervisors be better trained for initial critical incident response.

A second course, ICIR level 200, was also developed in response to recommendations 3.2 and 3.3 of the MacNeil Report. It requires 16 hours of in-person education. The RCMP *Course Instructors Handbook* describes it, first, as designed to better prepare supervisors to manage and supervise a critical incident until the critical incident commander takes over; and, second, as providing a mix of knowledge and training scenarios to convey the key aspects of taking and exercising command and control in the initial phases of a critical incident response. Some RCMP documents describe it as "basic level"[149] and, in the words of S/Sgt. Surette, as having the following features and genesis:

> [T]he biggest complaint from [the 2014 mass casualty in] Moncton, I think, had to do with communication amongst the Command Group with the frontline members, and that course is geared – there's other aspects, but a large part of that [course] is geared towards understanding the terminology that we [critical incident commanders] use and what our expectations are when we arrive, and who is actually in charge at that point.[150]

Geneviève Tremblay, the director of National Learning Services within the Learning and Development Branch of the RCMP, explained in her interview with the Commission that the online ICIR level 100 course and the in-class 200 course "bridg[e] the gap between our frontline officers and the Critical Incident Command, our Commanders, in the sense that there's, and we knew that; we've known this for a while that there's a gap between those, you know, those skill sets."[151] Ms. Tremblay and Supt. Lue advised us that the RCMP is now working on a further program, ICIR 300, that "closes the gap even more from the onset of that critical incident to when the ERT team actually gets there and they can get more stuff done."[152]

RCMP employment records show that the only member of the initial command group who had completed the ICIR 100 course by April 2020 was RM Rehill. RCMP documents state that this course had been available and mandatory for front-line

supervisors since at least 2018. The low completion rate among supervisors is problematic for at least two reasons. First and most immediately, it meant that these supervisors coordinated an initial critical incident response without having received standardized training in how best to direct that response. In this regard, in April 2020 they were in no better position than their colleagues had been in Moncton in June 2014 – despite the fact that the RCMP claims that this MacNeil recommendation has been implemented. Second, this training is characterized by the RCMP as mandatory for supervisors. When supervisors do not complete their mandatory training, what example are they providing to general duty members with regard to the importance of training? This leadership modelling is especially important in a paramilitary culture such as the RCMP's.

Employment records also show that none of the staff sergeants who contributed to the initial critical incident response, or Sgt. O'Brien, had taken the ICIR 200 course. S/Sgt. Rehill and S/Sgt. Carroll testified that they had completed a more robust in-person version of ICIR 100 training in 2011, but this was before the Moncton incident and the subsequent MacNeil Report. The evidence does not allow us to assess the extent to which this course included the components now taught in ICIR 200 or addressed the matters considered in the MacNeil Report. The learning product standard for ICIR 100 states that no challenge for credit process is available, meaning that the RCMP does not regard previous courses as equivalent to ICIR 100.

Acting Insp. Halliday, S/Sgt. Carroll, S/Sgt. MacCallum, and Sgt. O'Brien had completed their mandatory IARD training but not the online ICIR level 100 course or the in-person ICIR level 200 course. S/Sgt. MacCallum testified that, when he was a detachment commander, he had conducted scenario-based training based on the MacNeil Report recommendations and findings. Acting Insp. Halliday testified that he had a role in delivering IARD training in Nova Scotia and was a trained crisis negotiator. S/Sgt. Carroll was also a trained crisis negotiator. In short, these staff sergeants each had some training in critical incident response, but it was not standardized and was largely oriented toward front-line response and/or crisis negotiation.

Similarly, most of these witnesses testified that they had not completed tabletop or scenario exercises in which they had practised the role they later played in the critical incident response. Practice is an important aspect of critical incident preparedness because skills and knowledge of institutional processes fade over time unless they are refreshed. For example, for his role as risk manager, S/Sgt. Rehill had not

participated in tabletop exercises or other training scenarios for a critical incident. He had not participated in critical incident management training exercises with the Operational Communications Centre staff, although he had been part of an inter-agency tabletop exercise based on the scenario of a flood. Similarly, while he and others had participated in IARD training, including outdoor IARD training, it did not include or simulate the role of the risk manager, nor did the outdoor scenario incorporate the use of radios. Notably, although the 2017 H Division document "Risk Manager Roles and Responsibilities" states that risk managers are "trained incident commanders,"[153] neither S/Sgt. Rehill nor his risk manager colleague S/Sgt. Bruce Briers had critical incident commander training.

The experts who participated in the Commission's roundtable discussions emphasized the importance of ensuring that critical incident responders at all levels are adequately trained. Specific training and skill sets are required by those who have decision-making responsibility during critical incident response. We discuss these specific demands further in the section below.

The Attorney General of Canada submitted that, by rolling out the quick reference guide and the ICIR courses, it had implemented Ret'd. A/Commr. MacNeil's recommendations with respect to training front-line supervisors. However, the record leads us to conclude that, as of April 18, 2020, the sergeants and staff sergeants who formed the backbone of the initial critical incident command had received very little training in exercising command and control during a critical incident response. Beyond IARD training, which focuses on front-line response rather than supervision and command, any additional training they had received was not uniform within this group. **Most of these non-commissioned officers had not taken any of the initial critical incident response training that was implemented in response to the MacNeil Report, and none of them had taken ICIR 200.** Given the evidence that ICIR 200 is the course that teaches supervisors the key tactics and techniques necessary to provide interim command, this was a significant gap in the RCMP's preparedness. **The lack of consistent training and opportunities to practise requisite skills also likely contributed to the variation in these supervisors' understandings of their roles and responsibilities during the first three-and-a-half hours of the critical incident response in Portapique.** As we discuss in Chapter 3, this lack of training played a significant role in the communications failures that arose during the critical incident response.

MAIN FINDING

Risk managers and district supervisors were not adequately trained and had not practised for a large-scale critical incident response. The lack of standardized training, and the overall inadequacy of supervisor training, contributed to problems within the early critical incident response.

Before we turn to the role of the critical incident commander, the RCMP's submission that recommendations 3.2 and 3.3 in the MacNeil Report have been implemented warrants further comment. In his report, Ret'd. A/Commr. MacNeil detailed shortcomings in the initial critical incident response in 2014 in Moncton. For example, he identified that nobody had established a command presence or a unified tactical plan, that no supervisor had an overall view of the positioning of resources, and that an on-scene supervisor with situational awareness should have directed the perimeter control and response teams. He found that the execution of assigned tasks was not monitored and that general duty members continued to conduct unassigned tasks without direction. He summed up his conclusions as follows:

> **Chaos is unavoidable in the first moments of a dynamic and deadly situation; however, order should be restored as quickly as possible through supervisory coordination in the form of Command and Control. Structure, even when the structure offered is not perfect, is expected by members in a crisis** …
>
> Supervising an incident as dynamic as this is daunting, from the first officer killed until the last, just 20 minutes passed and crime scenes were spread over a distance of almost a kilometer. The speed, danger and complexity of the incident as well as the later influx of resources required strong operational awareness, sound tactics and decisive command and control.[154]

Ret'd. A/Commr. MacNeil specifically found that IARD training was not adequate to prepare supervisors for this responsibility. His recommendation "that the RCMP provide training to better prepare supervisors to manage and supervise throughout a critical incident until a [critical incident commander] assumes command"[155] was made in the context of these findings. Almost six years after Moncton, similar challenges arose in the critical incident response in Nova Scotia. The mandatory

90-minute online ICIR 100 course was inadequate to prepare these supervisors for the roles they played on April 18 and 19, 2020, and in any event most of the command group had not taken it. The optional in-person ICIR 200 course is more robust, and, had they completed it, the training would have assisted these non-commissioned officers. If they had all done this course, the confusion we have identified with respect to command structure would also have been less likely to arise.

We conclude on the basis of all the evidence that the measures the RCMP took to implement the recommendations in the MacNeil Report with respect to supervisor training were not adequate to prevent a recurrence of many of the shortcomings identified in it. A recommendation is not properly characterized as "implemented" if training has been designed in response to that recommendation but has not been completed by all or a large proportion of those to whom it is directed. The effectiveness of implementation is also a matter that should be carefully evaluated by the RCMP and the public. In this context, ICIR 100 is not an effective means of addressing the supervisory challenges that Ret'd. A/Commr. MacNeil identified and that we find recurred in the first three-and-a-half hours in Portapique. In this volume, we make further recommendations to address these shortcomings. In Volume 6, Implementation: A Shared Responsibility to Act we recommend an Implementation and Mutual Accountability Body to acquire and publish sufficient information to allow the public to meaningfully assess the adequacy of measures implemented in response to the recommendations made by this Commission. This transparency will ensure better accountability in the future.

MAIN FINDING

Most supervisors involved in the initial critical incident response on April 18, 2020, had not taken the mandatory online Initial Critical Incident Response (ICIR) 100 training. In any event, this training is inadequate to equip front-line supervisors with the skills necessary for a large-scale initial critical incident response.

LESSON LEARNED

Front-line supervisors play a critical role throughout a critical incident response, and they must be adequately trained to perform this role effectively.

Recommendation P.6

FRONT-LINE SUPERVISOR TRAINING

The Commission recommends that

The RCMP should commission an external expert review of its initial critical incident response training for front-line supervisors (ICIR 100 and ICIR 200), to be completed within six months of the publication of this Final Report. This evaluation should be published on the RCMP's website.

IMPLEMENTATION POINTS

This review should assess:

- whether existing mandatory training adequately equips front-line supervisors to exercise initial command until an accredited critical incident commander takes command (noting that present RCMP practice means that it may be several hours before a critical incident commander assumes command);
- the rate of compliance with mandatory training requirements among front-line supervisors;
- whether the existing ICIR 200 course adequately equips front-line supervisors to exercise initial command until an accredited critical incident commander takes command;
- the rate of completion of ICIR 200 among front-line supervisors; and
- whether ICIR 200 should be mandatory for front-line supervisors, with or without amendments.

Critical Incident Decision–Making: The Critical Incident Commander

On the night of April 18/19, 2020, two critical incident commanders were on call in H Division: S/Sgt. Jeff West, based at H Division headquarters in Dartmouth, and S/Sgt. Kevin Surette, based in Yarmouth, NS. S/Sgt. West received a phone call from Acting Insp. Halliday at 10:42 pm on April 18 and, at that time, initiated the call-out of the critical incident package (which required the approval of Supt. Darren Campbell, the support services officer). S/Sgt. West testified that he left his home after receiving the call, first to attend H Division headquarters and begin organizing the elements of his response. He notified S/Sgt. Surette of the incident at 10: 59 pm. Both these witnesses testified that, initially, the call was simply a notification to ensure that S/Sgt. Surette was aware of the incident and prepared to take over from S/Sgt. West if it became protracted. They emphasized that S/Sgt. West was the designated critical incident commander. S/Sgt. West explained:

> There's one Critical Incident Commander that's in control. The second Critical Incident Commander is there in a support role for anything to maybe some taskings. There may be just bouncing ideas off it.[156]

At 12:27 am on April 19, Acting Insp. Halliday called S/Sgt. Surette and they looped S/Sgt. West into the call. At this time, S/Sgt. West was still en route to Great Village, and S/Sgt. Surette was at home in Yarmouth. In his interview with the Commission, S/Sgt. Surette explained that in this call, Acting Insp. Halliday briefed them both on what was then known about the mass casualty and details of the critical incident response to that point. In this call, Acting Insp. Halliday suggested it would be appropriate to bring two critical incident commanders into the command post, given the magnitude of the incident. In testimony, S/Sgt. West and S/Sgt. Surette explained that it was unusual for uniformed command such as Acting Insp. Halliday to reach out directly to a second critical incident commander and bring that person into the response. However, S/Sgt. Surette testified that "at the end of the day, after that call, [S/Sgt.] Jeff [West] and I spoke privately and we made that decision" – that S/Sgt. Surette would also attend the command post.[157]

At 12:52 am on April 19, S/Sgt. West broadcast by police radio that he was lost (he had taken the wrong exit off the main highway and was not using GPS or a mobile work station to navigate). He arrived at the Great Village fire hall at approximately

1: 00 am. S/Sgt. West was driving, and his scribe, Sgt. Rob Lewis, was with him. S/Sgt. West and others set up the command post at the fire hall. He testified that as he drove toward Great Village, he was in regular communication with Cpl. Tim Mills, the team leader of the H Division Emergency Response Team (ERT), and also spoke to Acting Insp. Halliday, who was briefing him on information about the incident and what was then understood – for example, about the perpetrator's vehicle. When he arrived at Great Village, he had "a quick conversation" with Sgt. David (Dave) Lilly, who was attending to the Blair and McCully children, who had by then been evacuated from Portapique.[158] S/Sgt. West testified that he was monitoring the radio when able to do so, but did not consult CIIDS or the CAD log as he travelled toward Great Village and that he did not bring a laptop with him. He did not have access to mapping software or communications software until the tech support for ERT was set up, which happened sometime after he arrived. In the meanwhile, S/Sgt. West relied on a rudimentary hand-drawn map and description of the Portapique area. We will discuss the RCMP's information management and briefing practices in more detail in Chapter 3.

LESSON LEARNED

Critical incident commanders must have ready access to all of the equipment they need to perform their role.

Recommendation P.7

BASIC COMMAND EQUIPMENT

The Commission recommends that

Every critical incident commander should have a "ready go duty bag" with them at all times when they are on call. This bag should contain necessary equipment including police radio, RCMP cellphone, laptop with access to RCMP Computerized Integrated Information and Dispatch System and mapping technology, charging cables, critical incident commander guidebook, and checklists.

We identified at the outset of this chapter that the RCMP's policies and procedures appear to be based on the assumption that a critical incident commander will assume command of a critical incident response within a relatively short period. The evidence before us reflected a consensus about the importance of ensuring that the critical incident commander has adequate situational awareness and understanding of the critical incident and response so far, at the time of taking command.

In their expert report for the Commission, Dr. Laurence Alison and Dr. Neil Shortland (who have conducted many empirical studies with critical incident decision-makers) defined situational awareness as "a state in which individuals (1) understand the elements in their environment, (2) understand the relationship of those elements to each other, and (3) use this understanding to guide their behavior."[159] These authors explain:

> The significance of situational awareness [must not] be underestimated. In one study, Orasanu, Martin, and Davison (1998) discovered that most errors stemmed from poor situational awareness. Good situational awareness involves a decision-maker juggling multiple possible explanations for the critical incident before deciding and acting. Furthermore, good situational awareness involves updating our perception of an event as we receive more information as it unfolds.[160]

The RCMP's IARD policy (national *Operational Manual* chapter 16.10) directs that the scene commander must ensure effective transition of command and, if possible, remain with the critical incident commander after transition. This direction guarantees that the critical incident commander has access to as much information as is reasonably available to assist in gaining situational awareness.

Experts also cautioned us that situational awareness can be a misleading concept. Dr. Paul Taylor, a former police officer and tactical instructor who is now an academic at the University of Colorado in Denver, did his doctorate in criminal justice, with a specialization in police decision-making and, in particular, in error and resilience in police use-of-force decisions. He explained in a roundtable:

> I think we throw the term situational awareness around quite a bit. So the idea of global situational awareness would be ideal, right, that we kind of have this global understanding of what's happening. But the truth of the matter is, individuals pay attention to what's important to them in the

> moment, and again, they start – the information that assists them, particularly under time compressed situations, or where there's pressure to make a decision, I try and take in the information that's most important to me really in that moment. And so people don't ever lose situational awareness. They may not have global situational awareness or the situational awareness that we would want them to have after the fact, but they always have a situational awareness.[161]

Dr. Taylor's explanation is significant in two respects. First, it suggests the importance of attending to what information the decision-maker is focusing on at a given time and the circumstances in which that decision-maker is operating – for example, time pressures and competing demands. This approach provides a more contextual understanding than one that regards situational awareness as a binary in which the decision-maker either has, or lacks, situational awareness. Second, it introduces the notion of collective, or "global," situational awareness, which is a product of communication among those who may have different pieces of the overall picture. We will turn to the effectiveness of the RCMP's internal communications and information management in Chapter 3, and in that context we will evaluate the adequacy of the RCMP's processes for capturing and sharing important information during a critical incident response.

Dr. Alison and Dr. Shortland explain that decision-making is a process that is shaped by time pressures and the imperative of making a decision:

> While time spent initially can be beneficial for developing situational awareness, continuing to delay action while more information is obtained will eventually cost more (in terms of lost opportunities for intervention) than it pays (in terms of gaining relevant information) … In the critical incident context, the initial process of obtaining information can be hugely beneficial for understanding the problem at hand. However, this level of "return" may not be sustained over time – that is, the more information we get, the less useful it eventually becomes. This can lead to redundant deliberation (described above), whereby an individual continually seeks more information without significantly improving their understanding of the situation, their options, or the likely outcomes of their options.
>
> We have observed the tendency to defer decisions too long in our own research.[162]

Dr. Alison and Dr. Shortland explain that an attribute of effective critical incident decision-making is the capacity to take the time to assess different options carefully and then act quickly to implement the chosen course of action. These skills are not intuitive, and cultivating them entails a mix of individual aptitude and training. The authors emphasize the need for "a commitment to training and measurement of the effectiveness of that training. Training needs to be regular, of sufficient duration, and of sufficiently high intensity to stress-test officers' communication and decision-making skills."[163]

The significance of training and repetition to effective performance was also emphasized in our roundtable discussions. For example, Supt. Gossen spoke to these points:

> [T]he importance of that training; right? Those components of the command, control, communication, and having commanders experience that, having them work through the process under stress and not getting focused in on all the things that we know can happen to them under stress …
>
> But all of this – any training is dated; right? That repetition, that constantly doing it, all of these things are perishable skills. Even just remembering what SMEAC is a perishable skill over time and under stress is sometimes very difficult. That has to be trained constantly.[164]

"SMEAC" is an acronym used by Canadian critical incident commanders to remind them of the matters they should attend to within their decision-making. It stands for "Situation, Mission, Execution, Administration and Authorities, and Command, Control and Communication."[165] Supt. Gossen emphasized that, in order to be retained, the skills of critical incident command must be trained or practised regularly:

> Nobody is opening the book in the middle of a call and saying, "What's our, you know, Standard Operating Procedure for this?" They have to have – they have to experience it, either operationally or in training, to embed that in them and to be able to transfer that knowledge then on to the next people that they are training.[166]

The evidence before the Commission, including expert reports produced by Dr. Bjørn Ivar Kruke and by Dr. Alison and Dr. Shortland, emphasize that the work

of the critical incident commander is highly skilled and requires specialist training. Indeed, S/Sgt. West was very clear in his testimony that the specialist skills exercised by a critical incident commander are not readily transferrable:

> PARTICIPANT COUNSEL: Okay. Is it fair to suggest that Staff Rehill was also a temporary Critical Incident Commander?
>
> S/SGT. JEFF WEST: No, it's not a fair statement.
>
> PARTICIPANT COUNSEL: Okay.
>
> S/SGT. JEFF WEST: I think he is – at that point, Staff Rehill is helping control the initial critical incident response. He's not a Critical Incident Commander in the sense of training, skillset that goes with it.[167]

The expert reports with respect to critical incident decision-making emphasize that this skill requires aptitude, training, and regular practice. In their report, Dr. Alison and Dr. Shortland explain why critical incident decision-making is a particularly challenging domain:

> The problem with both traditional decision-making and recognition-primed decision-making models is that they struggle to explain decision-making when two conditions are present:
>
> (1) There is no clear "best" or "workable" course of action; and
>
> (2) The decision-maker is faced with a novel experience or problem and thus has no prior analogies to guide their decision-making.
>
> Our own work has reinforced that in many cases, these two conditions are indeed present during critical incidents and decisions that involve high uncertainty (see Alison, Palasinski, et al., 2017; Shortland, Alison, & Moran, 2019). As such, we have often found it useful to frame the process of [critical incident decision-making] not as a process of selecting the "best" outcome but as a process of calculating the "least bad" outcome. Most options are high-risk, most will carry negative consequences, and many will be immutable and irreversible once committed to (Alison & Crego, 2008; Shortland & Alison, 2020; van den Heuvel, Alison & Crego, 2012).[168]

Expert report writers and roundtable participants also emphasized that aptitude for critical incident decision-making is an important consideration. Supt. Gossen explained:

> [T]here's clearly individuals that are better suited to it than others … It's just, for whatever stranger reason, you have an emotional predisposition to being able to function in a high-stress environment. And that's not everybody …
>
> But identifying those individuals and fostering that skillset within your organization is crucial because they don't exist in abundance. That's been my experience. And, you know, organizationally, from a career-development position, you need to capitalize on those individuals, and allow them to operate in that environment that they are comfortable in.[169]

Dr. Alison and Dr. Shortland have examined whether certain personality traits are better suited to critical incident decision-making than others. Having studied more than one thousand police officers, firefighters, soldiers, and other practitioners, they have identified personality traits that do seem to lend themselves to effective decision-making. Although this research is in an early stage, it is promising and speaks to the value of collaboration between police organizations and academic researchers – a practice that is far more common in the United Kingdom and the United States than in Canada. Dr. Matthew McAllister, a physiologist at Texas State University who studies stress responses and resilience in emergency responders, said his research shows that "men and women respond differently to acute stress when you look at biomarkers, such that women actually tend to demonstrate lower concentrations of stress biomarkers when they're exposed to the same scenario as men."[170] Stress biomarkers measure an individual's physiological response to stressful situations. Dr. McAllister is studying the short- and long-term effects of stress on the performance of first responders.

In sum, critical incident decision-making is a highly specialized skill that must be carefully trained, regularly practised, and for which some people have a greater aptitude than others. Canadian police organizations have much to learn from the research in other jurisdictions about critical incident decision-making. Such research is not being conducted in Canada, we heard, because many Canadian police organizations are far less willing than their counterparts in the United Kingdom and the United States to collaborate with academic researchers. We return to this point in Part C of this volume.

Rural and remote policing face the challenge that specialist resources may be positioned some distance away from the scene of an incident – and in the mass casualty, that was the reality. On the night of April 18, 2020, both on-call critical incident commanders in H Division were based hours away by road from Portapique. It is also a Canadian reality that weather conditions can make travelling distances even more challenging, and some RCMP members, including S/Sgt. Surette, advised that poor weather impeded their response that same night. These factors raise the question of whether the RCMP model, in which a critical incident commander travels to a makeshift command post near the scene before assuming command, provides the most effective approach to critical incident response in the rural and remote areas that constitute a substantial portion of the RCMP's contract policing.

S/Sgt. West testified that when he arrived at Great Village, he and others set up the command post, taking steps such as positioning tables and flipcharts. Significantly, S/Sgt. West experienced challenges with his portable radio in the Great Village fire hall and had to move around to find a location from which he could broadcast. This difficulty meant, for example, that his first attempt to broadcast that he was assuming control of the critical incident response (at 1:19 am on April 19) did not go through. He successfully broadcast that he had taken command at 1:23 am. S/Sgt. West explained the process he followed before taking command: "[O]nce I arrive, I need to get – gather what information I can, get in a position where I'm comfortable, I'll be able to go on the air and announce that I am in control."[171] In the mass casualty of April 2020, **the RCMP's approach meant that no trained critical incident commander took command for more than three hours after the critical incident response began**. Even then, as we describe in the next section, at the time of taking command, the critical incident commander had not received a thorough briefing from those who had been most directly involved in the critical incident response to that point, including the risk manager.

In his review of the critical incident response in Moncton, Ret'd. A/Commr. MacNeil found that the critical incident commander had in that instance incorrectly focused on establishing a command post rather than on operational command. To provide context, the critical incident there began at approximately 7:20 pm on June 4, 2014:

> The critical incident CP [Command Post] was not operational until approximately 03:00 on June 5. **Quickly establishing an operational command post and taking control of the management of such a high risk incident is essential**. The first CIC, focused much of his attention during

> the evening of June 4 and early morning hours of June 5, setting up the CP at the Moncton Garrison, leaving the Ops NCO and Ops Officer at Codiac detachment, as the incident commanders, although neither have formal training in this area. The establishment of a suitable command post should have been delegated by the CIC while he focused upon carrying out his command role. The delay in establishing a command post should not have detracted from taking operational control.[172]

Ret'd. A/Commr. MacNeil did not make any specific recommendations on this point.

Witnesses explained that there can be a trade-off between setting up a command post more rapidly at a location some distance from the scene and taking time to travel toward the scene. In S/Sgt. Surette's words:

> [T]here are pros and cons, you know, time to get there, but keep in mind, the ERT team and the EDU [Explosives Disposal Unit] and the negotiators, they have to get there as well; right? So the Incident Commander is just another cog in that wheel. So getting there, that's going to take time regardless.
>
> Some of the benefits, yeah, I think probably with advances in technology, running it from a centralized location may work, but I never thought I'd say this about myself, but maybe I am old school. To me, I want to be closer. I want to be able to get a feel for what's going on as opposed to being detached, 2 or 300 kilometres away and looking at a screen.[173]

Similarly, Supt. Gossen observed: "Command Post location is always difficult. It's either too close or too far away. It's never in the right spot."[174] Witnesses also explained that a command post can be as simple as a vehicle, or – particularly in the case of a permanent command post – far more sophisticated. Ultimately, Supt. Gossen explained:

> [W]e certainly teach wherever you are, you are the Command Post. If you're the commander, and again, depending on whatever level you happen to be at, whether it's, you know, front-line constable, sergeant, staff sergeant, inspector, you need to realize that if you're in command, wherever you move to, you are the Command Post. So that could be standing at the back of a car or that could be in a separate room.[175]

We heard that some police services in Canada and Europe have addressed this conundrum by having a remote, fully equipped command centre located in the relevant police headquarters or near the operational communications centre. The centre is staffed by trained personnel who practise exercising their roles and responsibilities as a team and can be stood up at short notice. This strategy is coupled with ensuring that scene commanders are clearly designated and sufficiently skilled to make decisions that require detailed situational awareness effectively and to convey information as necessary to the central operations centre. In some instances, this approach is coupled with having an on-scene critical incident commander working from a command post near the scene.

We heard from many RCMP witnesses that the experience of responding to the mass casualty of April 18 and 19, 2020, was unlike any other task they had faced in the course of their career. For example, S/Sgt. Rehill testified, "It's a crisis beyond thinkable to comprehend it. It was a lot for me, yes."[176] Cst. Patton, who was a member of the IARD response in Portapique, described the conditions as follows:

> The structures are collapsing all around us. I mean, it's a war zone. There's the – the smoke from all of these fires is very low in the sky … So you've got the glow of the fires reflecting off the smoke. Some fires had been burning for some time and, like, anything that's inside of those houses, gas, barbeques, vehicles … and then the gun shots on tops of it, and then us trying to decipher between explosions and gun shots and – It was mayhem, yeah.[177]

Cst. Beselt agreed: "[I]t's like a war zone in there. Like you've never seen anything like it, so."[178]

Dr. Alison and Dr. Shortland explain that uniqueness is, paradoxically, a characteristic of critical incidents. It is this same characteristic that makes analogical reasoning unhelpful in critical incident decision-making: "In this case, anchoring to 'I'll do what I did last time' is the wrong decision-making strategy and can deter a decision-maker from fully developing situational awareness based on the particulars of the problem at hand."[179]

In a roundtable on June 2, 2022, Supt. Gossen agreed with Dr. Alison and Dr. Shortland's observation that analogical reasoning is often misleading in critical incident decision-making. He explained that the Canadian training for critical incident commanders seeks to counter that pitfall by orienting critical incident commanders to

"SMEAC" (see above) as a systematic decision-making process that orients them to the key values and decision-points they must follow. In our observation, the quick reference guide that the RCMP has provided to first responders in response to Ret'd. A/Commr. MacNeil's recommendation does provide a systematic decision-making approach. However, as Supt. Gossen observed, "Nobody is opening the book in the middle of a call."[180] The academics and experienced critical incident commanders from whom we heard universally agreed that training and practice are indispensable to cultivating this skill.

In lieu of analogies, Dr. Alison and Dr. Shortland have found that it is helpful to train critical incident decision-makers to engage in a practice they term "grim storytelling." They explain:

> Individuals often fail to imagine what could explain the behaviour they are witnessing … [T]oo often the first instinct is to fall back on the first probable explanation that comes to mind instead of engaging with multiple possible causes. To overcome this tendency, we encourage police officers and those training for critical incident decision-making to imagine the worst-case scenario. We call this cognitively demanding act "grim storytelling." Storytelling is an underutilized method of learning, despite its universality and primality throughout history (Gottschall 2012). The purpose of generating worst-case scenarios in [critical incident decision-making] training is to help practitioners learn how to respond. When cautiously and critically facilitated, learning through grim storytelling helps plan for, adapt to, and recover from traumatic events. It is a powerful learning tool that helps individuals to prepare for scenarios they may be unable to imagine otherwise.
>
> It is important to recognize that imagining the worst-case scenario, does not mean that it is the only plausible scenario. At the other end of the spectrum, an event or behaviour may be completely benign or at least less bad than anticipated. **So long as officers recognize that the worst-case scenario is just that – a possibility and not a probability – they can plan accordingly without catastrophizing. Considering worst-case scenarios gives officers a decision-making spectrum and allows them to consider the options within the widest framework.** This is especially important given the tendency to over-rely on seemingly analogous prior experiences, as discussed above. Grim storytelling can prepare

> decision-makers for the worst, such that if it happens, they can be more fully prepared and more accurately anticipate their next required moves.[181]

In Chapter 3, we identify how, by failing to examine a full range of explanations for the clear and consistent eyewitness evidence that the perpetrator was driving a marked police car, the command did not "consider the options within the widest framework." For now, we note that Dr. Alison and Dr. Shortland emphasize that grim storytelling is a learned skill and that some individuals have more aptitude for it than others. They have found in their work with many police organizations that police services frequently under-invest in training programs that help decision-makers cultivate these skills. They also emphasize that effective training need not be time consuming or elaborate:

> Simple exercises that are repeated frequently can be very helpful. For example, we used a program called "7 at 7" with Merseyside Police in Liverpool, United Kingdom. Three times per week and after a shift, officers would spend seven minutes discussing a difficult case they dealt with that day, seven minutes describing what would have turned it into a critical incident, and then seven minutes discussing what they had now learnt. This 21 minutes, three times per week, was viewed (via survey and focus groups) as a valuable, low-cost way of enabling them to learn and think creatively.[182]

LESSON LEARNED

Critical incident decision-making places unique demands on police and other agencies. Effective critical incident decision-making is a skill that can and should be taught to those who may respond to a critical incident. It is particularly important for those in supervisory positions.

Recommendation P.8

TRAINING FOR CRITICAL INCIDENT DECISION-MAKING

The Commission recommends that

The RCMP and other first-responding agencies should engage with appropriate experts and training institutions to incorporate "grim storytelling" and other skills of critical incident decision-making into basic and advanced training for police and communications operators. This training is especially important for critical incident commanders, risk managers, and front-line supervisors. These skills should be reinforced in critical incident command and emergency management courses and practised regularly.

In the initial hours of the critical incident response of April 18 and 19, 2020, several factors worked together to hinder the response at the command level: no scene commander was on site in Portapique; the lack of clarity about the command structure; the members in command had not practised together and lacked standard and adequate training; and the delay stemming from the decision by the critical incident commander not to take command until after he arrived in Great Village and set up the command post. By the time S/Sgt. West took command of the overall response at 1:19 am on April 19, more than three hours had passed since 10:01 pm on April 18 when Jamie Blair called 911 to report the incident. The MacNeil Report, expert reports prepared for the Commission, and roundtable evidence all make it clear that, when a mass casualty reaches the magnitude that was apparent to the RCMP by 10:30 pm on April 18, it is essential that a fully trained critical incident commander be placed in command as quickly as possible. In such high-risk circumstances, the paramount priority must be to ensure that an experienced critical incident commander is briefed and exercising command. If it is judged desirable to set up a command post near the scene, this responsibility can be delegated to those in the detachment who have a good local knowledge of the appropriate place to do so and, if necessary, the relationships necessary to request a space to use. An experienced and properly trained front-line supervisor should also attend the scene in order to secure the benefits of proximity that S/Sgt. West and S/Sgt. Surette described.

LESSON LEARNED

The highest priority in a complex critical incident response is to ensure that the response reaches the stage, as quickly as possible, where strategic decisions are being made by a fully trained and experienced critical incident commander with the tactical support of properly trained, well-equipped, on-scene, front-line supervisors.

C/Supt. Campbell testified that H Division has now established a Critical Incident Operations Room in its Dartmouth headquarters, immediately beside the Operational Communications Centre. He explained that this arrangement provides the critical incident commander and division management with the option to operate a command post from this room, which "has access to all the mapping, all the CAD [computer aided dispatch] data, all the information and also access to the risk manager as well because it's physically co-located."[183] He identified the mass casualty of April 18 and 19, 2020, as a "driving factor" behind the creation of this room.[184] However, he also explained that the decision whether to use the Critical Incident Operations Room or to take a mobile command post to a location nearer the scene is left to the particular critical incident commander.

Recommendation P.9

RAPID DEPLOYMENT OF CRITICAL INCIDENT COMMANDER

The Commission recommends that

The RCMP should put policies and standard operating procedures in place to ensure that an accredited critical incident commander with access to all relevant RCMP systems and infrastructure assumes command of a critical incident response as soon as possible after a critical incident begins, even if this means that the command post is physically distant from the critical incident.

IMPLEMENTATION POINTS

- In H Division, critical incident commanders should use the critical incident operations room in Dartmouth headquarters when this facility can be most rapidly stood up as a command post.
- The nearest detachment to the critical incident or another suitable place should be designated and staffed as a local coordination centre. Local commanders of other agencies (e.g., fire chiefs) should be directed to the local coordination centre, and a detachment supervisor should be in place to ensure that integrated command and shared situational awareness are maintained across agencies and locations.
- Moving to a model of remote command places even greater importance on the training and preparedness of front-line supervisors to act as scene commanders and local command. Districts should ensure that supervisors who are located in detachments are fully trained to exercise scene command, establish staging areas, establish a local coordination centre, and liaise effectively with other emergency responders and the remote critical incident commander.
- For a prolonged critical incident response, it may be appropriate for a critical incident commander to establish a local command post. In this circumstance, a second critical incident commander should be dispatched with all necessary equipment and support to that location, while the initial critical incident commander retains command from the remote command post.
- Media and public communication plans must ensure that the safety of media representatives, media liaison officers, and public communications staff is accounted for when local command locations, staging areas, and perimeters are established.
- The Incident Command System and Emergency Operations Centre models, presently used for integrated response to natural disasters and similar emergencies, may provide an appropriate model for this approach.

RCMP policy makes it clear that, once CIC West had taken command, he had "command and control of the incident and all **related resources**."[185] We heard that, in practice, a critical incident commander works at the head of a team (the command

triangle) that also comprises the Emergency Response Team leader and the crisis negotiator, with uniform command and the Major Crime Unit working under it. "Uniform command," as we said above, is an RCMP term for the district supervisory structure that has day-to-day responsibility for general duty members. Once a critical incident commander has taken command and the Emergency Response Team is engaged, general duty members will still have other roles to play – for example, providing outer perimeter control for the incident.

Witnesses emphasized the importance of collaboration within this overall structure. S/Sgt. Surette testified:

> I think what we have to realize is that [within] that command triangle, the ultimate decision rests with the CIC. That's true. However, it is very collaborative effort and, you know, the value of having everybody there, including in this case, the uniform and then [the investigative team] eventually, present, is that everybody hears all the ideas.[186]

Supt. Gossen explained the importance of fostering a trusting team environment in which those who are assisting in the critical incident response also feel able to contribute to the critical incident commander's decision-making process:

> As far as fostering the flow of ideas in a command post goes … it comes back to this team environment. If I make a decision in the command post that either the negotiator … or the tactical commander disagrees with, I fully expect them to say, "Hey, boss, I don't think we should do that, because of the information that I've got, my interpretation, because I'm the one directly talking to the chain of command on ground." And I have to take that as information in regards to whether, okay, maybe I don't make that decision.[187]

Given the magnitude of the critical incident on April 18 and 19, 2020, CIC West delegated many of the responsibilities detailed in clause 6.1.1. of the RCMP national *Tactical Operations Manual*, Chapter 1.1, to others, particularly to Acting Insp. Halliday in his role as head of uniform command. For example, Acting Insp. Halliday and those supporting him (S/Sgt. Carroll, S/Sgt. MacCallum, and Sgt. O'Brien) had primary responsibility for matters such as outer perimeter containment, engaging the Strategic Communications Unit, seeking alternative modes of air support once they learned that the RCMP helicopter was unavailable, and liaising with

other agencies. Cpl. Mills was team leader of the Emergency Response Team. As we explain in Volume 2, What Happened, given the shortages in the number of members of that team, he spent most of his time working as part of the critical incident response rather than in the command post. S/Sgt. Royce MacRae was the crisis negotiator. He attempted to communicate with the perpetrator by various means including email and phone, and, in addition, he prepared a profile of known information about the perpetrator. These members of the command group were supported by others including Glen Byrne, the commander of the Operational Communications Centre, and Cpl. Kevin MacDougall, who was providing technical support to the Emergency Response Team.

We discuss the flow of information between the critical incident commander and uniform command in greater detail in Chapter 3. For now, it is sufficient to note that the Emergency Response Team, Acting Insp. Halliday, and those under their direction continued to make decisions with respect to delegated tasks. S/Sgt. West testified that he generally presumed that tasks delegated to uniform command or elsewhere within the command post would be performed without further oversight or close supervision and that the team at the command post would use their judgment about what actions to take in furtherance of these tasks. For example, S/Sgt. Carroll told the Commission that the uniform command largely made autonomous decisions about outer perimeter containment even after CIC West took overall command:

> COMMISSION INVESTIGATOR: So, were you left, then, the autonomy then to move your resources that are containment points to where you saw would be most appropriate or would that still have to go through Jeff West, being the Incident Commander, if you wanted to move one car from one location to a different location, or were … were you guys given the autonomy to move your resources?
>
> S/SGT. ALLAN CARROLL: I believe we would, yes. We'd see what … we … we'd talk about it. We say, "Okay, yeah, we're … we're going to take these guys," because we did move them … Addie [MacCallum] moved one group up to … where they were initially placed, they were too far away. So, we move them, they were moved closer, they were … to a better … to a better point. One of the cars … when the kids move … when the kids moved out Sgt. Lilly and Cst. Grund, they departed. So, that left a little bit shorter at one area and we moved another car up to … to augment them. That … that didn't have to go through Jeff West.[188]

This approach may have contributed to problems in coordinating containment. Sgt. O'Brien testified that on one occasion, at about 5:00 am on April 19, he was given instructions by a manager to allow some general duty members to leave their assigned location at the top of Portapique Beach Road. After he broadcast this instruction, he was countermanded by CIC West, who directed those members to remain in their positions until otherwise advised. In his testimony, S/Sgt. West said that this incident "shouldn't happen. I don't know how it occurred. It shouldn't happen."[189] He also testified that this occasion was the only one in his time as a critical incident commander that such an incident occurred.

Overnight Command Decisions

At 1:13 am on April 19, 2020, as CIC West was preparing to take command, his timeline records a decision point: "[T]he suspect was still believed to be in the area; Priorities of Life." Similar notes appear at 1:24 am, 2:06 am, 2:11 am, 2:50 am, and 3:15 am.[190] At 3:25 am, CIC West's notes record "suspect yet to be located."[191]

By 2:30 am on April 19, CIC West and S/Sgt. MacRae were in position at the command post together with the uniform command team of Acting Insp. Halliday, S/Sgt. Carroll, and S/Sgt. MacCallum. Also present were scribe Sgt. Rob Lewis, tactical communications operator Glen Byrne, and the Emergency Response Team technical officer, Cpl. Kevin MacDougall. Sgt. Lewis was responsible for recording key information and decisions made by the critical incident commander. Mr. Byrne was monitoring the radio communications and responding to phone calls coming in to the command post as well as logging key movements and information into a record. Cpl. MacDougall was responsible for providing technological assistance such as maps to the command team. Cpl. Gerard (Jerry) Rose-Berthiaume and Acting Sgt. Angela McKay were at Bible Hill detachment in their capacity as members of the Major Crime Unit, which is tasked with investigation.

By 2:00 am, there were 18 marked RCMP vehicles providing outer perimeter containment, mostly along Highway 2. The Emergency Response Team's tactical armoured vehicle was in use, and Cpl. Mills and CIC West were directing ERT members to perform a range of tasks in Portapique and Five Houses. Throughout the night, those tasks included extracting Clinton Ellison and the IARD responders from Portapique, searching the Blair home, and responding to public reports of suspicious activity such as flashing lights in Five Houses. Members reported

hearing explosions or small arms fire at times. CIC West began making plans for the possibility that the response would continue into the daylight hours – for example, asking the J Division Emergency Response Team (based in New Brunswick) to mobilize. By about 3:30 am, after the IARD responders advised the command group that Andrew MacDonald was a surviving adult eyewitness, CIC West also began to task the Major Crime Unit with conducting interviews. At 4:04 am, he identified that the mission remained "contain the crime scene area in Portapique and locate and arrest suspect … This information had not changed from initial critical incident response."

The command triangle held a meeting at approximately 4:15 am on April 19, which was also attended by Acting Insp. Halliday. At 4:32, Sgt. Lewis recorded that the command group was considering the possibility that the perpetrator had died by suicide. At 4:42 am, CIC West's notes record a decision point at the conclusion of this meeting: "The suspect was still believed to be in the area, Priorities of Life, evidence preservation."[192] At 5:26 am, his notes reiterated the belief that the perpetrator remained in the area, reiterated priorities of life, and added "need to confirm the status of the victims and ascertain if the suspect may be barricaded in the residence."[193] A similar note appears at 5:47 am. (CIC West and others privy to this discussion appear not to have been aware that the burnt buildings included the perpetrator's properties.)

At 4:57 am, S/Sgt. MacCallum advised CIC West that he had moved a police vehicle to the corner of Highway 2 and Brown Loop, after noting that no member was blocking that intersection. Police who had been tasked with protecting Lisa Banfield's family members and the perpetrator's parents were, around this time, providing further information about the perpetrator and his relationship with Ms. Banfield. Members of the command group began to make arrangements to evacuate residents of Portapique. At approximately 6:30 am, Ms. Banfield emerged from the woods in Portapique. She was evacuated by tactical armoured vehicle, and investigator Cst. Terence (Terry) Brown began interviewing her at 6: 50 am. In the course of the interview, he provided updates to the command post about the information she shared with him. We address the information she and others provided at this time in Chapter 3. CIC West's notes between 6:00 am and 8:36 am – including those made after the command post received a photograph of the perpetrator's replica RCMP cruiser and information from Ms. Banfield's interview – continue to state, "The suspect was still believed to be in the area."[194]

As we describe in Chapter 3, the Operational Communications Centre began receiving 911 calls about the incidents on Hunter Road and Highway 4 in Wentworth at approximately 9:20 am on April 19, 2020. At 9:43 am, CIC West's notes record:

> Given the nature of the complaint, information received and the incident in Portapique area, it was likely that the suspect was no longer in the Portapique area and he had gone active after a significant period of no activity / sighting. Active mobile threat in a marked police vehicle, Priorities of Life.[195]

S/Sgt. West's timeline of decisions shows that the critical incident response was predicated on the belief that the perpetrator remained in the Portapique area throughout the night of April 18/19, 2020, and until the 911 calls began arriving from Wentworth at 9:30 am on April 19. The intersection at Highway 2 and Brown Loop was not monitored until approximately 5:00 am on April 19, and the command team's realization that this position was not protected does not appear to have prompted any reconsideration of the possibility that the perpetrator had escaped. At no point in this overnight period did any member of the command group make contingency plans for the possibility that the perpetrator had left the Portapique area.

S/Sgt. West and S/Sgt. Surette explained that their training and experience as critical incident commanders focused on scenarios in which the suspect is relatively immobile within a stronghold – for example, active shooting scenarios in schools and armed and barricaded suspects who may be holding hostages: "[I]n what we would term a traditional ERT call, we normally have containment of a confined area or building. It's not always that way, as we all know."[196] These critical incident commanders suggested that once the operation in Portapique expanded "to basically a manhunt to stop the threat," "it became even less of a critical incident, a typical critical incident call."[197] Supt. Gossen agreed that training for Canadian critical incident commanders focuses on armed and barricaded situations.

In a roundtable, Dr. Hunter Martaindale, a professor at Texas State University and the director of research at the ALERRT Center [Advanced Law Enforcement Rapid Response Training] (see Chapter 1), emphasized the risks that arise when those tasked with critical incident decision-making evaluate a situation on the basis of their expectations rather than the information they are receiving. He agreed with Dr. Alison and Dr. Shortland on the importance of training critical incident

decision-makers to consider the range of possibilities that may arise in a given incident. He explained that in the training offered at the ALERRT Center:

> [W]e definitely take an options based approach to how these events can unfold. As both [Supt.] Wallace [Gossen] and [D/Chief] Stephen [MacKinnon of the Cape Breton Regional Police] talked about, these are complex events, there's a lot of different things that can happen. [Rector] Kimmo [Himberg] said it as well. You don't know – you can't train for every possibility, so the officers have to have some sort of understanding of different options that could happen.[198]

As this comment illustrates, we heard a consensus on the importance of training critical incident decision-makers in an option-based approach. The experts also advised that these decision-makers should be cautioned not to anchor on a single explanation for what they were observing.

While they had some pieces of information earlier, it was not until approximately 9:40 am on April 19 that it became fully apparent to the command team that the perpetrator had in fact escaped Portapique, that he was driving a shockingly realistic replica RCMP cruiser, and that he was killing and threatening community members in the Wentworth and Glenholme area. As we next explain, what ensued was a scramble on the part of RCMP members to respond to these new incidents. The responding members were at a disadvantage when the critical incident response, which had been predicated on a relatively stationary, possibly barricaded, and possibly deceased perpetrator, became a manhunt across Nova Scotia's rural road system. Despite having made some efforts, for example, to account for the perpetrator's vehicles, the command group simply had not made plans for the possibility that the perpetrator was on the move outside Portapique. This lack of contingency planning persisted even after the command group became aware that the perpetrator's replica RCMP cruiser did not appear to be among the vehicles found in Portapique.

In Volume 2, What Happened, we found that the RCMP critical incident command did not adequately consider a wide range of scenarios, including worst-case scenarios, and failed to develop contingency plans based on the most logistically challenging possible outcomes. The command group's failure to consider the possibility that the perpetrator had escaped from Portapique, despite having some early information that made this possibility realistic, constituted an example of the failures in a decision-making process that Dr. Alison and Dr. Shortland describe in

their expert report. Specifically, the command team failed to consider the range of potential scenarios for the perpetrator's location and instead made plans on the basis of a single premise – the perpetrator's continued presence in the Portapique area. Had a member of the command team seriously considered the worst-case scenario – that the perpetrator had escaped Portapique with a vehicle that could be mistaken as a police car and with an arsenal of weapons – three important things would have changed within the critical incident decision-making. First, more attention would have been paid to contemplating where the perpetrator might have gone after leaving Portapique, and RCMP resources would likely have been devoted to searching beyond Portapique for the perpetrator. Second, the RCMP would likely have recognized the importance of sharing information with other police services much sooner and requested their assistance. Third, the command team could have made contingency plans for the possibility that the critical incident response would become mobile, and it would have been able to contemplate strategies, tactics, and how best to assign roles and responsibilities in that eventuality. As it transpired, more than 11 hours into the critical incident response, when it became clear that the perpetrator was an active and mobile threat, a fatigued command group was presented with a whole new set of circumstances and decisions to make under enormous time pressure.

The Shift to a Dynamic Response

RCMP policies regarding IARD and critical incident command, the MacNeil Report, and the Canadian Police College training for critical incident commanders are all largely predicated on the circumstance in which a perpetrator remains within a relatively small geographic area during a critical incident response. We learned in roundtables and from research papers that this orientation reflects the kind of events that prompted police services to generate IARD-type tactics and the critical incident command approach. Most active shooter and hostage incidents occur within a relatively small geographic area. The principle that general duty members should move toward an active shooter and not wait for specialist resources such as the Emergency Response Team to arrive emerged from studies of the police response in the Columbine High School shooting that occurred in Colorado in April 1999. There, 13 people died and dozens were injured. In that instance, many victims were shot and/or died of their injuries because general duty officers were trained to wait for specialist teams to engage a shooter. The principles taught in the

RCMP's IARD training, which are very similar to those taught by the ALERRT Center in the United States, were developed in recognition of the fact that general duty members may be required to move as a team to stop an active shooter and prevent further killings. After Moncton, the RCMP recognized that general duty members should also be prepared to respond to active shooters in outdoor environments, and an outdoor IARD course was added to the basic course (which teaches members to respond in a building such as a school).

It is possible that the command team's sense of the likely whereabouts of the perpetrator was partly shaped by expectations instilled by the scenarios used during training. S/Sgt. West reflected on the moment when he realized that the perpetrator had become a mobile active threat:

> [W]e've always talked early on [in the critical incident response as if this was] … a traditional critical incident armed barricade. Now we've gone from not a contained scene, not a contained location to a mobile … it really changes kind of some traditional thinking of dealing with it.[199]

S/Sgt. Surette agreed:

> [I]t's no longer a traditional ERT call for a number of reasons, so it becomes much more of a collaboration between general duty and our ERT responders … So in a case like this, we, as Incident Commanders, and we, as commanding the Emergency Response Team, have to rely on the [general duty] resources. There's a lot more of them out there, a lot more cars, more mobile, to help us try and track this guy down and try to hem him in.[200]

Both S/Sgt. West and S/Sgt. Surette referred to a "traditional" critical incident response as one in which the suspect is relatively stationary, armed, and barricaded in a building or otherwise fairly contained. The challenge that arises from training and policies that are implicitly predicated on particular kinds of scenarios is that members and decision-makers will be less well prepared for incidents that do not follow the expected pattern.

In this mass casualty, when it became apparent that the perpetrator was an active mobile threat, RCMP policies and standard training offered relatively little guidance about how best to coordinate the critical incident response. Despite this gap, the phenomenon of a mobile active threat is far from unknown within the RCMP's

critical incident response experience. For example, a critical incident in the Slocan Valley in British Columbia in October 2014 and a lengthy manhunt in northern Manitoba in 2019 similarly involved critical incident responses by RCMP members across rural and remote areas of these respective regions. After the mass casualty of April 2020, an incident in rural Saskatchewan in September 2022 similarly played out over a broad geographic area, leaving 11 victims dead and a further 18 injured in two communities across multiple crime scenes before a manhunt ensued.

We heard from RCMP witnesses who had been involved in the response on April 18 and 19, 2020, that the shift to a dynamic incident in which the perpetrator was mobile and his movements could not be readily predicted presented great challenges to the entire response. S/Sgt. Bruce Briers, who had relieved RM Rehill and was the risk manager on duty on the morning of April 19, explained:

> The problem with this [instance] is that we're – we were behind the eight ball and so you're trying to catch up to what of an individual that knows what they're planning on doing, and we don't have a clue, and there's a lot of areas. So trying to figure out where to best station people in relation to where he was last seen in the Debert area as opposed to – and where he's going. Because is he going to Halifax or is he going to somewhere else outside of that area?[201]

Supervisors who were involved in the critical incident response were unanimous in their testimony that the nature of the critical incident response changed significantly between 9:30 am and 10:00 am on April 19, 2020, when reports started to come in via 911 of the perpetrator's actions in Wentworth and Glenholme. S/Sgt. West described the nature of this shift as follows:

> [W]e get to the point, and it's almost our response within getting to the – it really comes a truly a collaborative response, effort with our uniform commander, how do we get our resources where we need to get them, maintain – recognizing that we still have crime scenes in Portapique that we have to maintain and protect … Now we have a mobile threat, and a lot of times, we'll almost equate it to it's almost like an IARD type situation that's physical, vehicle borne.[202]

In this phase of the critical incident response, members who had been performing assigned roles in the command post and elsewhere shifted their location and role

in response to information about the perpetrator's location and activities. In many instances, this shift occurred without the direction or even necessarily the knowledge of the critical incident commander and others whose work was integral to coordinating the overall response.

At around 9:40 am, as most available general duty and Emergency Response Team members headed toward Glenholme, Sgt. O'Brien left the command post at Great Village to provide scene security at Portapique. S/Sgt. MacCallum joined Cst. Craig Hubley, a police dog handler, to travel toward Glenholme, where the perpetrator was then believed to be located at the Fisher residence. S/Sgt. Carroll also briefly left the command post to accompany Sgt. O'Brien to Portapique. Before switching to these duties, S/Sgt. Carroll had been tasked with preparing a list of members on scene and their locations; S/Sgt. MacCallum had been tasked with liaising with the RCMP's Strategic Communications Team about sharing the recently received photograph of the perpetrator's replica RCMP cruiser with the public; and Sgt. O'Brien was assisting with placement of general duty members who were then arriving at Portapique to take over from those who had held containment overnight.

Each of these supervisors had also been performing other responsibilities – for example, S/Sgt. MacCallum was also the primary liaison with Halifax Regional Police officers who were performing a range of duties, from interviewing members of Ms. Banfield's family to securing the perpetrator's Dartmouth residence. These officers provided important information to the command team at Great Village.

In his testimony, S/Sgt. MacCallum reflected on his decision to join the response to Glenholme:

> I knew exactly where it was. I knew this driveway. I knew that civic only because I go up that road often. We camped nearby. And in my mind, it's like, "We finally know exactly where he is." …
>
> Everybody was, "Let's go." Like, everybody wanted to be in the fight. Everybody wanted to get there.

After it became evident that the perpetrator had departed the Fisher residence before RCMP members arrived, S/Sgt. MacCallum proceeded on to the scene of Lillian Campbell's murder to ensure that it was secure and that members positioned there were following safety protocols. Subsequently, he travelled to an intersection in Brookfield to act as a lookout.

Similarly, Acting Sgt. McKay and Cpl. Rose-Berthiaume had been assigned to work as investigators with the Major Crime Unit. They attended Bible Hill detachment in the early hours of April 19, 2020, and were briefed by Acting Insp. Halliday. Working from Bible Hill, they were organizing investigative resources, liaising with the Medical Examiner Service, and performing related tasks while monitoring the radio communications. These members were also assigning other trained members to conduct interviews of witnesses, including Andrew MacDonald, Lisa Banfield, and members of the Banfield family. At approximately 7:30 am on April 19, Acting Insp. Halliday had a discussion with Acting Sgt. McKay and Cpl. Rose-Berthiaume:

> It was starting to become daylight. Things had kind of, I wouldn't say calmed down, but they were actively searching for him, thinking that, you know, mostly likely, based on the containment, that, you know, he was there and possibly hiding out, and talking about – beginning to talk about, you know, how do we – how and when are we going to transition from a CIC response to a Major Crime response?[203]

Accordingly, Acting Sgt. McKay and Cpl. Rose-Berthiaume drove to the command post to meet with Acting Insp. Halliday and S/Sgt. MacCallum to begin a discussion about how best to secure the scene to allow investigators to begin their work, assign resources for witness interviews, and plan for other anticipated investigative tasks. In his interview with the Commission, Cpl. Rose-Berthiaume related how these activities changed when the RCMP became aware that the perpetrator had become a mobile active threat:

> In the middle of that conversation is when the radio went off in relation to the incident on the Wentworth Road with Lillian … Campbell. And subsequent to that, obviously another 9-1-1 call came in about a fire in – on Hunter Road. And then obviously the Fishers' call. And Cpl. McKay and I are in the MCU [Major Crime Unit] truck. We had the F150 that day. And we were driving around with the rest of the members that day trying to track down this individual.[204]

Cpl. MacKay recalled this moment in similar terms:

> [W]e never did take over the scene at that point. It was just we were starting to talk about it, that came over the radio. Everybody, we … [Cpl.] Jerry [Rose-Berthiaume] and I jumped up, ran out to the truck. We were

> in like, an unmarked black Ford – Ford pickup MCU vehicle. Jerry was driving. We jumped – jumped in the truck and we – and everybody was, ERT [Emergency Response Team], everybody who was in the area just left. I don't mean everybody, people in the CIC [critical incident command] would have – would have stayed put but ERT and any members that were able to be mobile, were mobile.
>
> ... We didn't have a – like, our vehicles don't have computers in the car, which would, you know, show the tracking of where we were. We left and the radio was very busy. And I was going to go on and, you know, sign in on the radio, but I just didn't want to take – I didn't want to take any time because it was already – you know, people trying to get in and, you know, it was a very critical situation ... People just got in cars and went out to – to help ... There was police cars everywhere.[205]

After that time, Acting Sgt. McKay and Cpl. Rose-Berthiaume joined the active critical incident response. They took no further steps to coordinate the investigative work until after the perpetrator was killed. The coordination role they had been playing for the investigative dimensions of the critical incident response appears to have lapsed in the meanwhile. At the time when the RCMP began chasing the perpetrator to Wentworth and Glenholme, there were eight known or suspected murder victims in Portapique, and five more had not yet been discovered by the RCMP.

At 9:56 am on April 19, Cpl. Shawn Puddester of Bible Hill Traffic Services alerted RM Briers that a general duty member who was not scheduled to be on duty had self-deployed and was travelling toward the last known location of the perpetrator without having logged into the mobile work station. "[W]e can't just have members dispatching themselves," he said, "because that's what happened in Moncton."[206] Cpl. Puddester was quite correct in his recollection that the MacNeil Report had cited lack of coordination of responding members as a problem in the critical incident response in Moncton in 2014. In that context, Ret'd. A/Commr. MacNeil made the following observations:

> A large number of members were eventually on site in Moncton and the command structure was not in place to deal with the influx of resources. This could have proven very dangerous; given the accused was in close proximity to the perimeter members who were positioned near the most recent sightings. Several members described not receiving or seeking

> direction and just "drove around," many of whom were not tracked by the Moncton OCC.
>
> Requesting additional resources with no plan to stage, manage and deploy them created an additional burden for already overburdened supervisors.[207]

Dr. Taylor also described the importance of a coordinated response in one of the Commission's roundtable discussions:

> As I've looked at responses to active shooter events across the country, I'm reminded very much of my son's first experiences on a soccer field … We can talk about what we need to do. But as soon as that ball is in play, everybody runs to it. And, you know, it doesn't matter what your assignment is, everybody's trying to get to the ball, and you end up with this mass of people around the ball, try to figure out what to do. If you want a team response that's effective, it takes training and coordination … the ideal response doesn't come together out of thin air. The ideal response really has to be coordinated, put into place, and practised between all of the entities that are going to be involved; otherwise, you get a rush to the ball, and in some cases, actually increase the complexity of the event through the response itself.[208]

The concern expressed by Cpl. Puddester on the morning of April 19 about members self-deploying to pursue the perpetrator was well founded. The Commission heard a great deal of evidence about general duty members leaving their assigned locations or duties in order to join the search for the perpetrator. It is also not clear that responsibilities were effectively reassigned when members left their assigned roles.

S/Sgt. MacCallum's observation that "everybody wanted to be in the fight" was likely true. The urgency created by the realization that the perpetrator had escaped Portapique and was actively killing community members while moving quickly through rural Nova Scotia must not be understated. However, as the evidence in Volume 2, What Happened, makes clear, a lack of preparedness for a mobile response and failure to coordinate overall activities created greater complexity and contributed to dangerous errors, including the Onslow fire hall shooting.

The effect that Dr. Taylor described was not well understood by RCMP witnesses. For example, when asked by Commission counsel about the decision RCMP

investigators made to pursue the perpetrator instead of beginning their investigation of the Portapique scenes, C/Supt. Campbell responded:

> [W]hen you have an active shooter, it's all hands-on deck. So, every gun, every member should have been in the hunt for him to stop him. And then you'll sort that other stuff out because the focus would have been stopping the threat.
>
> COMMISSION COUNSEL: Even the MCU [Major Crime Unit] detectives?
>
> C/Supt. DARREN CAMPBELL: Yes, yes. And you know what, if I was out there, I would have been doing the same thing myself.[209]

The RCMP's proposition that all members should have been actively engaged in stopping the perpetrator, regardless of their other responsibilities, takes the IARD principle of moving toward the threat well beyond its logical limits. Indeed, some of the serious risks inherent in that approach are acknowledged by the RCMP in its defence of the decision not to send a second IARD response team into Portapique because of the threat that blue-on-blue conflicts might arise. Other risks of uncoordinated self-deployment were documented in the Orlando Pulse nightclub report:

> Besides causing a chaotic situation, self-deployment . . . also deplete(s) the pool of available officers who might be needed to respond to different venues where multiple active shooting assaults are occurring. While it is a natural human propensity to rush in to help, an uncoordinated response instead results in chaos and ineffectual deployment.[210]

The authors of the Orlando Pulse nightclub report identify international examples of mass casualty attacks in which multiple sites were targeted simultaneously or in quick succession. They also state that self-deployment from a wide area around a mass casualty can make "a secondary attack … difficult to respond to and manage."[211] Fortunately, the mass casualty of April 2020 was not such a situation, but given RCMP supervisors' insistence that self-deployment is an appropriate response to an active shooter situation, it is necessary to convey this specific caution.

While it is appropriate for a group of responders to be singularly focused on finding and stopping the perpetrator, this tactic should not describe the entire

response. As we documented in Volume 2, What Happened, the focus on chasing the perpetrator to the exclusion of other responsibilities contributed to real harms, including the failure to pursue investigative leads, the failure to brief members as they joined the response, the failure to find victims or search for injured survivors in a timely manner, and the poor treatment of family members who sought information about those whose lives were taken.

Dr. Bethan Loftus, a criminologist at Bangor University in Wales, is a leading scholar of police culture, including police officers' responses to efforts to reform police culture. In an expert report prepared for the Commission, she explained that ethnographic studies of policing among many police officers have identified a preference for action and the lure of active crime fighting over other tasks. This preference is not universal, but Dr. Loftus suggests it may be strongly associated with the masculine ethos that is also prevalent and valued within many police services. Evidence that "every member should have been in the hunt"[212] and references to "the fight"[213] and to taking down[214] suspects are examples that reflect the cultural valorization of action and crime fighting that Dr. Loftus describes, as are the repeated requests of one RCMP member who had been assigned to scene security to be allowed to join the search for the perpetrator. In contrast, Acting Cpl. Heidi Stevenson's calm and team-oriented approach of ensuring that her members had key information, positioning them at strategic locations around Shubenacadie, and, when asked, sending two members to provide back up in Colchester County demonstrates Dr. Loftus's point that these attitudes are not universal among police officers. We also note that Sgt. Darren Bernard expressed concern at the lack of coordination of the critical incident response and took command of the Shubenacadie cloverleaf scene, seeking to ensure that the crime scene was preserved and that Acting Cpl. Stevenson was treated with respect while the search for the perpetrator continued. He also took steps to ensure that communications challenges caused by general duty members operating on separate police radio channels were made known and addressed (see below). A diversity of skills and abilities, strategic thinking, and effective leadership is critical for any successful team-based response.

MAIN FINDING

Different members responded in different ways during the response to the active mobile threat presented by the perpetrator. In general, though, the overall emphasis on chasing the perpetrator, rather than coordinating a strategic response to ensure that other necessary tasks were also completed, impeded the effectiveness of the RCMP's critical incident response and, at times, caused additional harm.

The departure of some personnel from the command post necessitated a reconfiguration of command responsibilities. Acting Insp. Halliday testified that once the response shifted its focus to chasing the perpetrator, command and control of the general duty member response was transitioned back to the risk manager. By this time, S/Sgt. Briers had taken over from S/Sgt. Rehill in that role. Acting Insp. Halliday explained that this transfer made sense because RM Briers could "more easily maintain control and observation of who was where, who was coming on, where they were, where they were going."[215] S/Sgt. Briers had completed a five-day in-person Initial Critical Incident Response course in 2016. In his testimony, he described his understanding of the task he was assigned on April 19, 2020:

> That I need to bring extra resources in, so bring more members in, police officers from around other surrounding areas. So I had to do that, as well as trying to figure out where to set up roadblocks and checkpoints in order to try to contain it. And this is a very big area, so I knew I needed more people … I had to bring extra people in to get them on the move, and then try to coordinate the people that were there in the meantime to take over, you know, to do – to try to find him, and/or set roadblocks up.[216]

CIC West broadcast the information that RM Briers would be directing uniform members by radio at 10:20 am on April 19. Other evidence indicates that he had been tasked with this responsibility a few minutes before that announcement was made. At about the same time, the Emergency Response Team was shifted to a dedicated radio channel, while general duty members who were involved in the critical incident response remained on the Colchester radio channel or on their respective county channels (for example, some were on the Hants County channel). S/Sgt. Dan MacGillivray, who assumed overall command from CIC West at 10:20 am (having arrived at the command post at approximately 10:00 am)

proposed this change in both command structure and communications approach. He explained in his Commission interview that he suggested this change because the shift to a dynamic search for the perpetrator made it particularly important for the Emergency Response Team to have "dedicated radio space to be able to talk to one another." Under this revised approach, the critical incident commander continued to direct Emergency Response Team members.

Ret'd. A/Commr. MacNeil's observations about the significant burden of giving busy supervisors additional members to manage are reflected in the radio communications among uniform members and the risk manager between 10:20 am and 10:30 am on April 19, 2020. In this period, having been given command of general duty members, RM Briers sought to place those members in strategic locations, alert the Truro Police Service to the fact that the perpetrator might be heading toward Truro, and monitor the information coming in via 911 calls and the radio, among other tasks. At times, including immediately after the Onslow fire hall shooting (which occurred at 10:21 am), he attempted to communicate by radio but was unable to do so. While the transition of Emergency Response Team members away from the Colchester radio channel served its purpose of giving the Emergency Response Team a dedicated communications channel, traffic on the Colchester radio channel remained very heavy.

At about 10:45 am, S/Sgt. Steven (Steve) Ettinger, who had experience as a risk manager, joined RM Briers at the Operational Communications Centre to provide him with further assistance. However, in his testimony before us, S/Sgt. Briers reflected that having this assistance had been less helpful than might be expected because the two staff sergeants were obliged by the physical constraints of the centre as it was then laid out to share a desk, work station, and phone. We found in Volume 2, What Happened, that handing coordination of general duty members to the risk manager not only created additional difficulties in coordination between the command post and general duty members but further overburdened the risk managers and the Operational Communications Centre. This step was taken at a time when the centre was busier than experienced members had ever seen it. The resources necessary to coordinate general duty members – including access to CIIDS and radio communications – were available in the command post. This responsibility should have remained with the command post, both to alleviate pressure on the Operational Communications Centre and to keep that responsibility co-located with the overall command of the Emergency Response Team in an environment in which general duty members and Emergency Response Team members were responding virtually side by side.

CHAPTER 3

Information Management During the Critical Incident Response

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Introduction

As we documented in Volume 2, What Happened, the first three 911 calls on the evening of April 18, 2020, provided crucial information to the Operational Communications Centre (OCC). The perpetrator's name was provided, as well as the fact that he was driving a car that looked like an RCMP vehicle although he was not a police officer. By 10:30 pm that night, community members who knew and recognized the perpetrator had given the RCMP a clear and consistent account of his identity and of his replica RCMP cruiser. This chapter explains how this information was lost to the critical incident response.

We explore in this chapter how the RCMP discounted the clear and consistent information it had received from community members who recognized the perpetrator and described his replica RCMP cruiser. We find that the RCMP's information management practices were inadequate, both in the OCC and in the command post, and that, having anchored to an explanation for what they believed community members must have observed, the command group failed to take investigative steps that would have tested their assumptions. We conclude that the routine processes used by the RCMP to elicit and capture information from community members are lacking. We also build on our conclusion in Chapter 2 that investigation was undervalued relative to reactive pursuit of the perpetrator, showing how this cultural orientation influenced the command group's focus in the overnight period on April 18/19.

In Volume 2, What Happened, we document further examples of important information shared in 911 calls, where the significance of this information was not recognized within the OCC and/or it was not acted upon by the command group or responding members. For example, had a few more questions been asked, Jody MacBurnie's 9:20 am call on April 19 expressing concern about Sean McLeod and

Alanna Jenkins should have been an early indication that the perpetrator might have been on Hunter Road in Wentworth. Similarly, calls by concerned family members and community members about the Oliver and Tuck family and the Bonds should have prompted earlier investigation of Cobequid Court in Portapique.

In focusing on the RCMP's failure to accurately record and fully consider information shared by Portapique community members about the perpetrator's identity and his replica RCMP cruiser, we do not intend to suggest that these examples of failures in information management are unique. Rather, we focus on them here because they demonstrate the failure in "grim storytelling" and in planning for the worst-case scenario that Dr. Laurence Alison and Dr. Neil Shortland identified as being a common failing of critical incident decision-making that can be countered with appropriate recruitment, training, and practice.

The Perpetrator's Identity and Replica RCMP Cruiser

At 10:04 pm on April 18, 2020, three minutes after Jamie Blair called 911, Acting Cpl. Stuart Beselt, Cst. Vicki Colford, Cst. Adam Merchant, and Cst. Aaron Patton were dispatched to Portapique. Ms. Blair's call had been taken by OCC call-taker Ms. Donna Lee Williston. As RCMP members drove the approximately 50 kilometres between the Bible Hill area and Portapique, two further 911 calls were received in the OCC. One of these calls was placed at 10:16:24 pm by AD, who, after witnessing the murder of his parents, Greg and Jamie Blair, had taken shelter with his sibling in the McCully family residence with the two McCully children next door to the Blair home. This call was taken by Mr. Patrick Brent. The third call, placed at 10:25:25 pm from Orchard Beach Drive in Portapique by Andrew and Kate MacDonald, was taken by Ms. Carol Howardson.

Ms. Blair and Mr. MacDonald were shot by the perpetrator while on the phone with 911 call-takers. Ms. Blair died immediately from her injuries, and efforts by the OCC to call her back failed. Mr. MacDonald fortunately survived his wounds and, with his wife, Kate MacDonald, who was with him in the vehicle, was able to drive approximately 500 metres to the intersection of Portapique Beach Road and Highway 2.

There, the MacDonalds met RCMP first responder Acting Cpl. Beselt. Ms. MacDonald also provided information via 911 and then directly to RCMP members as they arrived at Portapique. Meanwhile, Mr. Brent stayed on the line with AD and the three other children, including AB.

By 10:30 pm on April 18, each of these 911 callers had separately:

- identified the perpetrator by his first name, or by the common shortened form of that name;
- identified that they recognized him because he was a near neighbour or owned a home in Portapique;
- stated that the perpetrator was driving a marked police car; and
- specified that the perpetrator was not a police officer.

Ms. Blair explained specifically that the police car was "RCMP … it's decked and labelled RCMP."[1] It was evident from the information Mr. MacDonald shared over the course of his 911 call that he initially mistook the perpetrator's car for a genuine police vehicle, but then – after he was shot – identified the shooter as his neighbour, the perpetrator. Ms. Blair and AB both explained in their calls with 911 that the perpetrator was a denturist or "works in Halifax as like a denture person."[2]

Both AD and Mr. MacDonald shared the further information that buildings were on fire in Portapique. AD said that the perpetrator had set fire to the Blair home, and Mr. MacDonald relayed his observations of two house fires on Orchard Beach Drive. AD and AB's call and the MacDonalds' call were each briefly patched through to fire dispatch.

Acting Cpl. Beselt arrived at the intersection of Portapique Beach Road and Highway 2 at approximately 10:25 pm. Within moments after Mr. MacDonald drove away from the perpetrator, he encountered Acting Cpl. Beselt at this intersection. Mr. MacDonald and Acting Cpl. Beselt knew and recognized one another, and Ms. MacDonald remained on the 911 line with RM Brian Rehill while Mr. MacDonald spoke with Acting Cpl. Beselt. At approximately 10:31 pm, after confirming that the MacDonalds were speaking with members on scene, RM Rehill ended the call with Ms. MacDonald, who then spoke to Cst. Colford in person.

At 10:30 pm, Cst. Patton, who was then at the top of Portapique Beach Road, conveyed the following information over the Colchester RCMP radio channel: "It's someone named [shortened form of perpetrator's first name], he has a car that looks like a police car, he's 50–60 years old."[3] The RCMP obtained the perpetrator's

full name from property records at about the same time, and Cpl. Natasha Jamieson, who was then driving toward Portapique from Millbrook, suggested that the OCC conduct a vehicle registration search in the perpetrator's name. Meanwhile at 10:31 pm, dispatch broadcast the information – obtained from AD– that the perpetrator's vehicle "looked like a cop car with a symbol on the side of it."[4]

Accordingly, by 10:30 pm on April 18, the RCMP had received crucial information from community members about the man who was shooting people and setting fires in Portapique. This information was clearly stated and consistent across multiple eyewitnesses who spoke independently to 911 call-takers, RM Rehill, and the RCMP members who first arrived at Portapique. The information provided by these community members tallied with information that was obtained by the RCMP from property records at 10:30 pm on April 18. This is not a situation in which the information shared by community members was conflicting or ambiguous. To the contrary, given the circumstances, it was remarkably clear and consistent.

Receiving and Processing Information

The circumstances in which information was conveyed were chaotic and traumatizing for community members. In Volume 4, Community, we described the evidence we heard about the short-, medium-, and long-term impacts of mass casualty incidents on survivors, community members, and those whose loved ones are killed in such events. These circumstances were also very challenging and distressing for OCC staff and RCMP members. During the active phase of the mass casualty, OCC employees and their supervisors carried extreme emotional and psychological burdens. Ms. Williston, who spoke to Ms. Blair, heard screaming as Ms. Blair was being killed. Mr. Brent, who ultimately spent more than two hours on the telephone with the four children at the McCully residence, was responsible for keeping these young children safe and relatively calm, in circumstances where two of them had just witnessed their parents' murder and two others knew that their mother had gone outside to confront the person who had committed those crimes. Ms. Howardson heard Mr. MacDonald get shot during his 911 call, almost immediately after a fire dispatcher queried whether he was safe. RM Rehill was tasked with

coordinating the initial critical incident response, and Ms. MacDonald appears to have been patched through to him by mistake.

In a roundtable, we heard from Dr. Arija Birze, who is a postdoctoral fellow at the University of Toronto. Dr. Birze is one of the few researchers who has studied the emotional and cognitive dimensions of the work performed by emergency communications workers. Dr. Birze's research shows that 911 call centre workers, who are mostly women, carry an unrecognized and uncompensated burden of emotional labour:

> At all times – whether interacting with the public, frontline emergency service workers, co-workers, or supervisors – [emergency communications workers] are required to simultaneously manage their own emotions while evaluating and managing the emotions of others, in their ongoing efforts to discern pertinent public safety information in organisationally sanctioned ways.[5]

In her interview with the Commission, call-taker Ms. Donna Lee Williston, who took Ms. Blair's 911 call and continued working on the night of April 18/19, 2020, observed: "there's no crying on dispatch."[6] In a subsequent small group session with OCC staff members, OCC supervisor Ms. Kirsten Baglee reflected on the morning of April 19, and in particular on the time when she learned that the perpetrator had killed Acting Cpl. Heidi Stevenson and was trying to obtain medical attention for Cst. Chad Morrison, who had been shot and injured:

> [N]ot having time to really react to, like to emotionally react, we certainly reacted in our – in our action and in – and in getting him [Cst. Morrison] the help and in getting people there for Heidi as quick as we could, but the – the emotional reaction couldn't happen at that time because we had a job to do.[7]

Ms. Baglee and her colleague Mr. Bryan Green articulated the horror associated with the period in which the manhunt was unfolding. Mr. Green explained:

> [W]e realized really quick that the only way we're getting any information is for something else horrific to happen. So every call that came in was worse than the next one, and that's the only way we knew where he was, and we were always 30 seconds behind him, and that was tough.[8]

The OCC staff and RCMP members who dealt directly with community members during the critical incident were faced with a dire example of the need to manage one's own emotions while eliciting important information from civilians who were experiencing horrific trauma and, in many instances, were in immediate danger. They were also responsible for imparting information to terrified persons, including children, to try to keep them safe and calm. Emergency Health Services dispatcher Bruce Cox, who faced similar challenges when speaking to those who called 911 on the morning of April 19, reflected in another small group session:

> [O]ne of our primary, you know, as an MRT [Medical Response Team] dispatcher, is the safety of the caller. That's our paramount goal, is the caller is safe. And, you know, if they're not safe, you know, our directive is leave … I wished I could have done more for the people who had contacted us.[9]

Equally, the initial responding RCMP members at Portapique set up containment and established an Immediate Action Rapid Deployment (IARD) strategy while seeking to orient themselves to an unfamiliar place in a rural community at nighttime. Responding members consistently described the darkness, fires, smoke, and noise of explosions at Portapique as terrifying, with many comparing the scene in Portapique that night to a war zone. Some were also dealing with terrified, traumatized, and injured civilians. Those responders who entered Portapique witnessed murdered persons, initially without tending to the dead, given their responsibilities to try to locate the perpetrator, protect the children who were sheltering in the McCully residence, and assist surviving community members. Although emergency responders often encounter traumatizing scenes (and this can have its own cumulative effect on their well-being), the conditions on April 18 and 19 were not those that Canadian police routinely encounter. Under these circumstances, the RCMP members who were responding directly – whether as part of the IARD response, on the Emergency Response Team (ERT), or while providing containment – could not reasonably also have been expected to fully monitor and evaluate the flow of information that was being shared by radio.

Good institutional practices are required to ensure that responding members receive the information they need, and that the information they share is in turn properly captured and shared with the command team. In the next section, we consider the evidence we heard about best practices for emergency communications centres, and about the RCMP's policies and procedures.

Information Management Within the Operational Communications Centre

In a roundtable, we heard from Kerry Murray-Bates, who is the manager of the Toronto Police Communications Centre. Having served as a call-taker and dispatcher, she now oversees that 911 call centre and has been in command of the police communications centre for critical incident responses to mass casualties such as, in 2018, the Danforth shooting and the Toronto van attack. In the Danforth shooting, a perpetrator killed 2 people and injured 13 others along Danforth Avenue, Toronto, in July 2018. The strip where these shootings happened is a busy area with many restaurants and cafés. In the Toronto van attack, 11 people died and 15 people were injured when a perpetrator drove a van along a busy sidewalk on Yonge Street, Toronto, in April 2018. Ms. Murray-Bates was working as manager of the Toronto Police Communications Centre when both of these incidents occurred.

Ms. Murray-Bates explained that at the Toronto Police Communications Centre, standard policies and procedures are carefully designed to require communications operators to perform the same skills and actions in every case. These policies and procedures are scalable, so that even during a highly complex critical incident, the work performed by communications operators is very familiar to them:

> [T]he key really is to put in place training that is scalable, so it's the same thing every time, it may just be on a larger scale. And then, of course, for us, depending on what's happening, of course, that can shape what happens next, the questioning that the call takers do, the actions that dispatchers take based on the size of the event. But our policies and procedures are quite clear, and they are very scalable. So they – if an event is larger, it does outline what we do next.[10]

Good training, robust institutional policies, and standardized procedures that can be scaled up as necessary for large-scale incidents determine the quality of performance in challenging circumstances. These institutional features ensure that information shared by eyewitnesses, including civilians and responding emergency services personnel, is captured, analyzed, and shared in the ways that best support a successful critical incident response. The training, policies, and procedures that Ms. Murray-Bates described are the standard by which we evaluate the approach within the RCMP's Operational Communications Centre.

We wish to emphasize the importance of Ms. Murray-Bates's point that good process is scalable – that is, process should remain much the same as an incident grows in scale or complexity. Excellent information elicitation practices and record-keeping procedures should be routine within any emergency operations centre. Adopting these practices for high-frequency incidents has intrinsic benefits for the quality of the day-to-day work performed by emergency services. It also has the advantage that, when effective information management becomes absolutely imperative – as it does in a large-scale critical incident response – good practices are already habitual and do not require extra cognitive effort at a time when the mental and emotional demand on staff is likely to be at its highest. As Commissioner Alexandra Bech Gjørv reflected in her report on the critical incident response to the 2011 terrorist attack in Oslo and Utøya, Norway, "[w]hen time is short and many things are taking place simultaneously, it is difficult to learn anything new."[11]

The RCMP's policies with respect to the training and work of call-takers and dispatchers are set out in the national Operational Communications Centre Manual. This manual addresses topics including standard operating procedures, core training requirements, field coaching, and block training. National OCC policy provides that "OCC employees will … record information accurately and concisely in an occurrence"[12] (5.1.2) and "obtain all available information required to safely dispatch the appropriate police response"[13] (5.1.4). Where a call relates to an incident of which the OCC already has notice, the employee will "[r]ecord any new information provided by the client and client's particulars"[14] (7.1.3). Block training requires OCC employees to have completed two Introduction to IARD courses (both general and outdoor active threats) and to successfully complete a scenario-based training exercise based on a "high risk / low frequency" event every 24 months.[15]

In addition, H Division has a manual of standard operating procedures and protocols. This manual, which is more than 330 pages long, details procedures and policies for answering calls, creating files and posts for dispatch, and for dispatchers to follow. It contains procedures for specific scenarios such as activating the Emergency Response Team, responding to an expected death, and "domestic disputes."[16] The manual includes five pages addressing the procedures that should be following in an "active shooter / active threat" situation.

The Commission's research indicates that the management of information as part of critical incident response is a relatively underexamined subject. Within the limited literature that does exist, the role of 911 call-takers and dispatchers and their supervisors in capturing and sharing information is particularly overlooked. We found two noteworthy exceptions to this general trend. First, the Gjørv review of

the 2011 terrorist attack in Oslo and Utøya found that the importance of information provided by community members who witnessed the bombing in Oslo was not recognized by a call-taker or the call-taker's supervisors. In one striking example from the Norwegian response, 10 minutes after the perpetrator had exploded a bomb outside a government building in Oslo and almost two hours before he began an attack on Utøya island,

> a new witness made a call that was answered by a switchboard operator at the Oslo Operations Center. The witness informed her about a man dressed in a police uniform, with guns and a helmet, leaving the area prior to the explosion in a civilian car with the registration number VH24605. This witness described the route of the car leaving the area. The operator who received this information decided to interrupt the witness, referring to how busy things were and ending the call.

This was, in fact, an accurate description of the perpetrator and his vehicle. This information was not properly documented by the call-taker, nor properly handled by supervisory staff. Other callers also communicated that the person associated with the van that had exploded had left the area by vehicle. Commissioner Gjørv concluded that the failure to recognize the significance of this information and pass it along to the incident commander meant that responding police did not receive the credible description of the perpetrator or learn that he had left the scene. As a result, police officers did not search for the person and vehicle described by this witness, and the incident commander failed to recognize and plan for the risk that the perpetrator was at large and planned to commit further terrorist acts elsewhere.

A second exception to the gap in the research on information management is provided by a small but growing body of research literature that demonstrates that the information shared by 911 dispatchers plays a crucial role in shaping first responders' understanding of a situation and their responses to it.[17] Using a variety of methodologies including experimental studies and close analyses of real incidents, these researchers have found that police responders rely heavily on dispatched information when confronted with ambiguous or uncertain information on scene. They have called for more attention to be paid to how call-takers and dispatchers are trained and how they perform their work.

In order to gain a better sense of the work performed by communications operators, we obtained evidence about how this work is performed in the RCMP's Operational Communications Centres and by police operational communications centres

elsewhere in Canada. The Commission produced a Foundational Document on "911 Call-Taking and Dispatch," which summarized the 911 call system in Nova Scotia and explained the set-up, policies, procedures, and technologies available to the RCMP Operational Communications Centre in Truro in April 2020. This Foundational Document also provided some information about how the OCC has changed since April 2020, including as a result of its relocation to Dartmouth, Nova Scotia. (This relocation is not a response to the mass casualty; it was already being planned in April 2020.) Further information on this topic was shared by RCMP witnesses including Supt. Dustine Rodier, C/Supt. Darren Campbell, OCC commander Glen Byrne, and OCC supervisor Ms. Jennifer (Jen) MacCallum. A 2019 workload analysis of the Truro OCC identified the need for additional staff, and RCMP documents suggest that the OCC remained understaffed in April 2020. We heard evidence from OCC supervisors that, after the mass casualty, the OCC staffing went from 50 to 24 full-time operator positions, "most of those lost due to Portapique one way or the other."[18]

Ms. Murray-Bates described the skills required of call-takers and dispatchers in some detail, and explained how the Toronto Police Communications Centre recruits and trains these communications professionals. She summed up the difficult work that call-takers must perform in the following way:

> I mean, our call takers really try and – first of all, they have to make sense of what's coming in. They have to try and understand what the caller is telling them. But there's care here as well; right? So if a person is calling 911, there's a level of care that needs to happen as well ...[19]
>
> We train our dispatchers and our call takers to be methodical in that we have patterns that we do things. So we won't say tell us – describe the suspect or describe the person with the knife. We'll say, "Okay, we're going to get descriptions. The person with the knife, male or female? White, Black, Caucasian – or white, Black or Asian? How tall are they?" Right? So we have a process, so that we can keep the caller guided and focussed.
>
> We will record everything that the caller tells us. And we do it in a way that the caller advises. This is what the caller is seeing. We have to remember that our call takers aren't seeing this. They're basing everything on what is being told to them on the telephone. So they will report everything, and it will go into the text of the event. So as the call taker is getting more and more information, the dispatcher is able to see that information in real time and continue to broadcast that for the responding officers.[20]

Ms. Murray-Bates explained how the Toronto Police Communications Centre ensures that these skills and procedures can be followed in an instance where the scale of the event is greater, for example in the circumstances of a mass casualty:

> You realize very quickly the scope of the event. We don't draw any conclusions as to what's happening because there's that period of kind of making sense as to what's happening, and we, as I said, we operate the same way every time. But depending on what's happening, it allows us to kind of shape our questioning.
>
> ... And in the case of the Danforth shooting, the 911 calls were coming from people on the Danforth that were impacted, and we saw that. Those people were pulling injured people into their stores. And so as that was being reported and the situation was being reported, our call takers were asking questions like, which direction was the suspect walking, were they by themselves, to give the officers more information as they were responding, right, as well as the descriptions and stuff. But we were also giving citizens – asking citizens, are you able to barricade yourself in? Can you be unseen? Can you hide; right? Are you able to lock yourself in? How many people are in your store? How many people are injured? Can they walk? Are they mobile? So all of that information is important for not only engaging what's happening and dealing with the, in this case, the shooter, but also for the afterwards where we're finding injured people and officers are following up, doing checks on properties, et cetera, and the ambulance and the fire response.[21]

She also explained the role that is played by dispatchers, who both convey to first responders the information being received by call-takers and capture and direct the information received from first responders:

> 50 percent of the dispatcher's job is to give out information but also to receive information, and make sure that everyone else that needs to hear it hears it. So often, our dispatchers will repeat what the officers have said, and make sure that everyone – so it actually gets broadcast twice.
>
> The other thing that they do is they prompt officers. So as I said, normally officers will get dispatched to an event regardless of the scale, our routine, our dispatchers will say, "First unit on scene to advise", and then they will prompt. They will say, "Is there any update? Is there any update? Is there ..." So it prompts officers to share the information and to

> vocalise what it is they're seeing and experiencing, so then we can gauge and other officers can gauge what's happening and the need for further response, additional response.[22]

Further, Ms. Murray-Bates explained how the information shared by call-takers will be framed by dispatch:

> [W]e report exactly what the caller tells us. We report what we hear in the background. We report how the caller presents. If the caller makes a statement and says they're at a specific location, but we can see from their wireless GPS they are not, we report inconsistencies, and we use language that speaks to that. We don't make statements. We don't say, "The person has a gun." We say, "The caller believes the person has a gun."[23]

Where different callers provide inconsistent information, this, too, will be shared by dispatch so that first responders "can make assessments in their response and take that information into consideration as they decide what action they're going to take."[24] At the same roundtable, Dr. Hunter Martaindale observed that the system Ms. Murray-Bates described is "exactly what we would hope people were doing out there. They're giving them every piece of information as the civilians are giving it to them."[25]

The little research that exists on 911 call-taking and dispatch shows that emergency communications centres play a keystone role in police responses to community requests for assistance. **In all instances, 911 call-takers play a crucial role in eliciting and capturing the information shared by community members.** Dispatchers are responsible for ensuring that this information is in turn shared with responding members by means of radio, text, or both. Dispatchers also play a coordination role, for example, capturing information shared by responding members and sharing information with other agencies. We accept Ms. Murray-Bates's evidence that, in order to do this work well, emergency communications centres must have robust and consistent processes for all calls, and that these processes should be scalable for highly complex incidents such as a mass casualty. In the next section, we evaluate the RCMP Operational Communications Centre's processes to capture and share crucial information, as these processes operated on April 18 and 19, 2020.

Information Management Within the Operational Communications Centre on April 18 and 19, 2020

In the following passage, we provide a detailed account of the information captured by call-takers and conveyed by dispatchers, and that was shared by first responding RCMP members in Portapique. Our intention in providing this account is not to criticize the work done by specific individuals under extremely difficult circumstances, but to evaluate the effectiveness of the RCMP's training, policies, and procedures and the Nova Scotia Emergency Management Office's standard operating procedures, which also apply to OCC employees. We are specifically concerned with the procedures adopted within the OCC to capture and disseminate important information. Accordingly, we first consider the information that was received and recorded or not recorded in the RCMP's incident activity log and shared or not shared by dispatchers over the police radio. We then evaluate the extent to which the RCMP's information capture and dissemination processes allowed OCC staff, first responders, and supervisors to recognize that consistent information was being shared by community members who had recognized the perpetrator and were reporting his identity and the details of his replica RCMP cruiser.

The incident activity log that was commenced with Jamie Blair's 911 call at 10:01 pm on April 18, 2020, summarizes that call as follows:

> 911 husband shot and lying on the deck. soc [subject of concern] [first name of perpetrator] (?)(?) com [complainant] said there was a rcmp car in yard sac [*sic*] had a huge gun. uk [unknown] where soc is now.[26]

This summary of the information provided by Ms. Blair was incomplete in a way that highlights the importance of capturing exactly what a 911 caller reports seeing. In her call, Ms. Blair said, "There is a police car … There is an RCMP … it's decked and labelled RCMP … [Inaudible] … but it's not a police officer."[27] She explained that she recognized the perpetrator, gave his first name, and said he was a denturist. Neither the fact that Ms. Blair recognized the perpetrator, nor his occupation, are reported in the log. The information that there was an RCMP car in the yard was captured in the incident activity log without the extra information that Ms. Blair

provided. This incomplete summary may reflect the limitations of the incident activity logging software. We heard that the RCMP's software is aging and due for replacement, but did not receive evidence that suggested, for example, that there are any limits on the number of characters that may be used in a log entry.

At 10:04:08 pm on April 18, Ms. Williston added the following information to this incident activity log: "open line. screaming."[28] The log records that Ms. Williston tried to call Ms. Blair back at 10:04:27 pm but was unsuccessful. In the recording of the 911 call, gunshots can be heard at around the time of the screaming, but this was not noted in the log. In an affidavit supplied to the Commission, Ms. Williston said, "At this time, I have no independent recollection of hearing a sound I believed to be gunshots during my call with Ms. Blair."[29] She did not listen to Ms. Blair's 911 call again that evening. Ms. Williston explained, "In order for someone to listen to the 911 calls afterward, it would require them to do so in the supervisor's office. As I recall, this is done on a separate system" on which she was not trained.[30]

The inability to easily play back 911 call recordings represents a significant shortcoming that should be addressed in the RCMP's emergency communications centre systems. As the information captured (and not captured) in the incident activity log from this first 911 call demonstrates, providing ready access to 911 call recordings would assist OCC employees, supervisors, and risk managers to review calls and see whether important information has been overlooked, particularly when a call is as challenging as Ms. Blair's call was. Having routine access to 911 call recordings is also a useful feedback mechanism, allowing call-takers to evaluate the extent to which they have captured important information from past calls.

LESSON LEARNED

Public safety answering point policies and procedures should ensure that information obtained via 911 calls or from responding members is captured, even if its accuracy or significance cannot be ascertained in the moment. To support this objective, it is important for communications operators and supervisors to have ready access to 911 call recordings to ensure that all relevant information from a 911 call can be captured and conveyed to responding members.

Recommendation P.10

CAPTURING INFORMATION FROM 911 CALLS

The Commission recommends that

All staff at the RCMP Operational Communications Centre and staff at other public safety answering points should have access to 911 call recordings at their desk and be trained in how to play calls back.

IMPLEMENTATION POINT

Standard operating procedures should encourage call-takers, supervisors, and risk managers to review calls whenever it may assist them to glean more information or review the completeness of the incident activity log.

The incident activity log notes that dispatcher Mr. Matthew Russell first viewed this file at 10:04:24 pm, OCC supervisor Ms. Jen MacCallum viewed the file at 10:04:25 pm, and RM Rehill began monitoring this log at 10:04: 54 pm. Ms. MacCallum explained in an interview with the Commission the steps she took immediately upon first seeing this incident activity log:

> I ran over to the call taker because that would have been the quickest way at the time just to see if she was okay, first of all, and to see if she had any other information in regards to it. She did not. It was basically as brief as that, and I could just tell with her facial expression that that's basically what she had written, it was all we had.[31]

Ms. MacCallum also asked Ms. Williston whether she believed that this was a genuine call, and not a prank: "Obviously, it was not" a fake call.[32]

An ambulance was dispatched at 10:03:59 pm on April 18, and the first responding RCMP unit confirmed that they were en route to Orchard Beach Drive in Portapique at 10:04: 54 pm. Some subsequent calls, including one by Jamie Blair's child AD and a call placed by Portapique resident Allison Francis were later merged with this incident activity log, while others, such as the MacDonalds' call, were not. In fact, the Commission received no evidence of an incident activity log being created for the MacDonald call.

In her Commission interview, Ms. MacCallum explained that the Operational Communications Centre experienced new challenges with the incident activity log on the night of April 18/19, 2020, as the volume of data contained within the log grew:

> [A]s much as our equipment is fantastic and the software is great, everything that we were putting in that running log was being added to by all of us and including the Risk Manager, which was a lot. So, not that it would flash before your eyes, but you definitely would have to be cognizant of what was going on. There was also once the file got bigger because more information was being put on it, it started to glitch, which apparently nobody nationwide had known at that time about because there had been no event as significant as this before using that software program. So, when I say when it started to glitch, it … there would be a delay, quite a significant delay. So, I would open it up and it would take three to four minutes for it to actually fill and tell me what was going on, if there was any new information being added.[33]

These challenges were greatest as the critical incident response became prolonged. We do not understand them to have affected the capacity to log information in the early stages of the mass casualty.

Ms. Murray-Bates similarly identified that, as the number of calls about an incident grows very large, the software used in her facility can become strained. The Toronto Police Communications Centre has adopted procedures to manage this limitation:

> So each caller, when you realize it's the same event, because it will be at the same location, we can just put that information into the original call, so we're able to have one event. Now there are challenges with that as well because the one event gets very large very quickly and that has an impact on the technology.
>
> So we can create separate events, CAD tickets, if you will, for the same event, but we also have the ability to link them together. We call it a cross-reference. And then the technology, what the technology does for us is it allows any cross-referenced events, the event number to show, so that we can access those event – we don't have to go looking. It's right there for you.[34]

In order to address the shortcomings with the incident activity log on April 18 and 19, 2020, the staff at the OCC deployed runners (staff who moved back and forth

between the call-takers, dispatchers, supervisor, and risk manager to convey information) and internal messages. It is important to note these problems for two reasons. First, they impeded the effectiveness of the log as a tool for capturing and sharing information. Second, because of the measures adopted to address these shortcomings, the incident activity log is not a complete guide to the information that was captured and shared between call-takers and dispatchers. Our record simply does not explain why some 911 calls, such as the MacDonalds' call, were not included in the incident activity logs maintained in the OCC.

RCMP members were first dispatched to Portapique at 10:04:03 pm on April 18. Dispatcher Mr. Matthew Russell broadcast the following information:

> I just sent it down … it says here 911, husband shot and lying on the deck, SOC [first name of perpetrator], but it says (inaudible) there was an RCMP car in the yard – SOC had a huge gun, unknown where SOC is now.[35]

At 10:04:44 pm, Mr. Russell provided the updated information that "they got an open line of just someone screaming there, the uh, the premise history – nothing."[36] Cst. Colford requested a text version of the information. The information that had been provided by Ms. Blair, but was not contained in the log, was not broadcast by the dispatcher or otherwise shared with responding members.

As the RCMP members drove toward Portapique, they sought additional information from the dispatcher. In response to Acting Cpl. Beselt's query about whether a vehicle description was available, Mr. Russell replied "10-10 [negative], we got nothing for the vehicle but where the complainant said something that there was an RCMP car in the yard."[37] Mr. Russell also conveyed the call-taker's impression that the caller "sounded terrified."[38]

AD called 911 at 10:16:24 pm from the McCully home next door to the Blair home on Orchard Beach Drive in Portapique. AD described the vehicle driven by the perpetrator as "a police car" and said that he couldn't find the licence plate.[39] Call-taker Mr. Brent's efforts to elicit a further description of the vehicle were initially unsuccessful. At 10:18:30 pm, in response to the call-taker's request for more details, AD explained, "Just like the um … like a police car."[40] The incident activity log was updated to reflect this information. At 10:19:02 pm, Mr. Russell broadcast an update to the original call: "It says, ah, female com called saying that her mom and dad were both shot, the dad is outside, the mom is in her bedroom. Ah, and then it

says here, com saying it was a police car."[41] Mr. Russell again broadcast the information that "it was a police car" associated to the subject of the complaint.[42] The call transcript shows that call-taker Mr. Brent asked AD which direction the perpetrator went, and AD was unsure. At the time when information shared by the children was initially broadcast to the first responders, Cst. Merchant queried the possibility that these calls could be *Mental Health Act* related. Acting Cpl. Beselt later explained:

> [W]e get a variety of calls. A lot of times they're mental health calls, and you know, we get all kinds of calls from mental health people that are suggesting that something's happening and you get there and it's not, right … I probably go to 100 mental health calls where people are alleging something happened rather than the actual thing, right. So you know, like you're trying to get that information and a confirmation of whether or not that's actually occurred.[43]

Cst. Merchant added that this consideration "didn't change our speed. We're still flying out there. But you're just trying to understand what's going on."[44] The dispatcher immediately stated that there was no basis to think that this was so.

At 10:21:09 pm Mr. Russell further updated the information about the suspect car, stating:

> [T]he complainant is now telling us that the – the police car has just took off and … we haven't been able to ah, assess if – it is actually a marked police car, 'cause he did say something around at first about it being – not a regular police car.[45]

Another constable suggested at this point that the vehicle used by a process server in a nearby community might be mistaken for a police vehicle. The responding members, who were still en route to Portapique, then shifted to discussing their approach to the scene. Acting Cpl. Beselt used his radio to encourage responding members to stop and put on their hard body armour and to remind them of the need for a cautious approach.

Whether because of software constraints or differences in process, the OCC staff did not follow the practices described by Ms. Murray-Bates: "we report exactly what the caller tells us. We report what we hear in the background" and as new information comes in, the dispatcher reminds officers of information already broadcast while also providing updated information.[46]

The practices described by Ms. Murray-Bates are necessary and important to any Canadian emergency communications centre. They provide significant support to responding members and community members by ensuring that information shared by witnesses, the significance of which may not yet be apparent, is communicated to first responders and supervisors. The practice of repeatedly broadcasting important information, accompanied by disciplined radio protocols for other transmissions, also makes allowance for the fact that a member who is racing toward a chaotic and dangerous scene may not be able to monitor the radio at every moment, and may not have sufficient working memory available to recall exactly what information has already been broadcast.

As Dr. Paul Taylor explained in a roundtable on June 1, 2022:

> [E]ven our best-laid plans, we have to insert the human element into that. And as human beings, we're not perfect … when we're designing our tactics, where we're thinking about the tools that we're going to use, we really should be – we really should be thinking about and designing around the expectation for human failure, that people aren't going to get it right.[47]

In order to best support responding members and those tasked with analyzing information, 911 call-takers and dispatchers should be trained to capture and convey exactly what the caller has said, as well as to capture and convey other information obtained from the call, such as background noise. Training dispatchers to routinely support responding personnel by reminding them of the key information that has been gathered by call-takers about an incident, including inconsistent information, would also greatly assist responding members. The software used by OCC staff must also be sufficiently robust to allow them to capture all the details shared by call-takers and should not be limited to a summary of the information.

Recommendation P.11

INCIDENT LOGGING SOFTWARE

The Commission recommends that

The RCMP should review its incident logging software to ensure that it allows call-takers and dispatchers to capture all information, and that standard

operating procedures ensure that Operational Communications Centre staff members are able to capture all relevant information, even for complex incidents. These procedures should be scalable so that, during a critical incident, communications operators are following the same procedures they follow for more routine calls.

Recommendation P.12

CALL-TAKER TRAINING AND STANDARD OPERATING PROCEDURES

The Commission recommends that

(a) The RCMP and Nova Scotia Emergency Management Office should review call-taker recruitment and training to ensure that 911 call-takers are trained to capture all information shared by a community member as fully and accurately as possible, and to listen for background noises or information that may also be important for first responders.

(b) RCMP dispatchers should be trained and standard operating procedures should require that information obtained by call-takers be shared using standard language that signifies the source of the information (e.g., caller says she saw the person carrying a gun; call-taker heard possible gunshots in the background of the call). Important information should be shared repeatedly, and updates or conflicting information should routinely be identified.

While the four members from Bible Hill were travelling toward Portapique, staff members at the OCC were trying to make sense of the report that witnesses had seen a marked RCMP vehicle. At 10:05:06 pm on April 18, Ms. MacCallum broadcast a query over the Cumberland County encrypted radio channel about whether any of their marked vehicles could be in Portapique. She initially received a negative answer, but an RCMP member subsequently suggested that an RCMP sergeant, David (Dave) Lilly, may have a cottage in Portapique. Cst. Patton also confirmed over Colchester radio that Cumberland County RCMP had no vehicles in Portapique.

RM Rehill was aware that Sgt. Lilly's name had been mentioned, but it is not clear what significance he attached at the time to this information. RM Rehill's notes do, however, include a notation that suggests that he was aware that community members who had called 911 had identified the perpetrator by his first name. When he testified, S/Sgt. Rehill was asked about how he made sense of the information that was then being shared about the potential police vehicle. He explained:

> We don't know at what point what are they calling a cop car. And then the Dave Lilly comment, like, I'm saying, what is going on here? Do we have a police officer out there or did a police officer's car get stolen?

S/Sgt. Rehill's testimony identifies the range of possibilities being considered by the risk manager before the OCC received calls from AD and the MacDonalds. Had he received more of the information shared by Ms. Blair – specifically her very clear statements that she recognized the perpetrator, that he was not a police officer, and that he was driving a "decked and labelled" RCMP vehicle, some of these possibilities would have become more likely and others less so.

Including this information in the incident activity log might also have allowed call-taker Mr. Brent to prompt AD further when he initially sought a description of the police vehicle. At approximately 10:30 pm, the Blair and McCully children and Mr. Brent had the following exchange:

> AD: [inaudible] … There's a car.
>
> All kids speaking in panic: It's not …
>
> AD: Guys, it's not [perpetrator's first name]. Oh, by the way, he's probably gonna blend in with the cops because he has a cop car.
>
> CT07: Oh, okay.
>
> …
>
> CT07: How do you guys know it was a cop car? Did it have lights and stuff on it? Or …
>
> AD: Yeah, it did. Well, it just looks like that.
>
> AE: And it has … it has the cop symbol on it, like …
>
> AB: And he owns a cop car.

> AD: Yeah, he does.
>
> AB: Cause he owns like seven Ford, like, white Ford cars. They're like all identical.

This exchange is captured within the incident activity log at 10:30:55 pm with the following summary: "[AD] saying the soc veh looked like a cop car with the symbol on the side."[48] Both the information that the vehicle was a marked car and the information that the perpetrator owned "like seven" white Ford Tauruses were important. Again, the latter information was not captured in the incident activity log. If it had been captured, it would have been an early clue that the two white Ford Tauruses subsequently found burning in Portapique and the third found at the perpetrator's property in Dartmouth might not be the only Ford Tauruses the perpetrator possessed. This information would also have made less likely the theories that the perpetrator might be driving a stolen police vehicle and that the perpetrator might be a genuine police officer.

Meanwhile, Andrew MacDonald called 911 at 10:25:25 pm on April 18, 2020. When he reported that he had observed fires, the OCC call-taker patched him through to fire dispatch. After some initial discussion, Mr. MacDonald reported, "There's a police officer in the driveway." The fire dispatcher immediately asked, "RCMP are you aware of the situation that's going on, on that road?" Ms. Howardson responded, "Yeah. Just he's saying there's two houses now on fire so we just thought we'd update you there." Soon after this, Mr. MacDonald reported, "the police officer is parked at this driveway but I don't know what the, like he's coming around. I don't know if he's going to talk to me or what." The fire dispatcher interjected, "Is it safe for him to be on that road?"[49]

Within seconds, the call transcript records, "Shots fired. Female screaming." Mr. MacDonald reported, "I've been shot." The OCC call-taker responded, "Fire, so you aware there's possibly a shots fired?" Mr. MacDonald then said, "It's our neighbour, [shortened form of perpetrator's first name], he just shot me in the arm." At this time, Ms. MacDonald took over and said, "Please help us. My husband just got shot. My husband just got shot." The call-taker asked, "Yes Ma'am. Is there a police officer there?" Ms. MacDonald responded, "He's. It's not a cop. It's not the cops. It was somebody else."[50] Soon after this, the call-taker patched Ms. MacDonald through to the risk manager, S/Sgt. Rehill. S/Sgt. Rehill asked Ms. MacDonald a number of questions, including whether her husband knows the person who shot him. Ms. MacDonald responded, "Uh, [shortened form of perpetrator's first name]? I don't …" The risk manager clarified, "[shortened form of perpetrator's first name]

something or other?" and Ms. MacDonald responded, "Yes."[51] The risk manager also clarified the information about a police car:

> RISK MANAGER: Did you see a car?
>
> MS. MacDONALD: Yes.
>
> RISK MANAGER: What ...
>
> MS. MacDONALD: Somebody in a cop car shot at us.
>
> RISK MANAGER: In a cop car.
>
> MS. MacDONALD: We thought it was a cop car, I don't know.
>
> RISK MANAGER: Was it white?
>
> MS. MacDONALD: Yes.
>
> RISK MANAGER: Stripes?
>
> MS. MacDONALD: I think so. Yes.
>
> RISK MANAGER: Did you see any roof lights on it?
>
> MS. MacDONALD: No.[52]

At this time, which was approximately 10:30 pm, Ms. MacDonald advised RM Rehill that they were now with actual RCMP members. S/Sgt. Rehill ended the call and Ms. MacDonald subsequently spoke to Cst. Colford.

We have recounted the MacDonalds' 911 call in considerable detail because a number of important points emerge from a close consideration of it. First, the fire dispatcher's immediate questions about whether RCMP is aware of what is happening on Orchard Beach Drive, and her alarm at the possibility that the MacDonalds were unsafe, suggest that she had recognized the consistent information that a perpetrator who could be mistaken as a police officer had been reported to have shot people and to be setting fires in Portapique. However, from her response, the OCC call-taker appears not to have been aware of this information, or not to have recognized the significance of Mr. MacDonald's report that he could see a police car in a driveway on Orchard Beach Drive.

A second important point emerges from a close review of the information shared by the MacDonalds: it was consistent with the information that had previously been

provided by Ms. Blair and the information that was being provided by the Blair and McCully children at around the same time. The MacDonalds recognized the perpetrator and provided his name and the fact that he was a neighbour. Ms. MacDonald provided some details that were consistent with the suggestion made by the other two callers that the perpetrator was not a police officer but was driving a marked police vehicle. Had the information being provided by community members been more fully captured in the incident activity log, and had the procedures described by Ms. Murray-Bates been followed, this consistency between the community members' accounts would have been apparent.

The third important point is that the information shared by the MacDonalds in their 911 call was not logged in the incident activity log, or seemingly in any log. Nor – perhaps relatedly – does any of this information seem to have been dispatched to RCMP members via radio. Members who had by that time arrived at the top of Portapique Beach Road did share some of the information they received from the MacDonalds via radio. The first mention of these survivors on the radio channel arose at 10:28:24 pm on April 18, when Acting Cpl. Beselt reported, "Found some victims here."[53] He followed up at 10:29:32 pm with, "We may have other people shot here too."[54] Dispatcher Mr. Russell confirmed receipt of this message: "10-4, copy that."[55] Cst. Patton, who was speaking to Andrew MacDonald, confirmed at 10:30:21 pm: "It's somebody names [short form of perpetrator's first name], he has a car that looks like a police car, he's 50–60 years old … He owns a denture ah, company in Dartmouth."[56] At 10:35:57 pm, Acting Cpl. Beselt added, "Apparently the suspect has a – the old police car with markings on it."[57]

At around this time, Acting Cpl. Beselt and Cst. Merchant began travelling south down Portapique Beach Road on foot. Cst. Patton left shortly afterward, joining up with his colleagues to form an IARD response by approximately 10:40 pm. (The precise times are not certain, as they were not broadcast by radio, nor were the members prompted to broadcast this information by the call dispatcher or RCMP supervisors who were monitoring the radio traffic.) At 10:37:41 pm, Cst. Colford radioed that she was "gonna just … wait for ambulance here with" the MacDonalds. Soon after this, Acting Cpl. Beselt confirmed, "As far as we know we have an active-shooter in here."[58]

The incident activity log captured some of the information shared by the responding members, but by no means all of it. At 10:30:46 pm, Mr. Russell added a note: "[short form of perpetrator's name] 50 to 60 years … owns denture company in dartmouth … drives car, like a police car."[59] Perhaps most significantly, the incident

activity log did not capture the information that surviving eyewitnesses who recognized the perpetrator, one of whom had been shot, had been seen by responding members. This gap compounded the failure to make any record in the incident activity log of the MacDonalds' 911 call.

The MacDonalds called 911 and encountered RCMP members at precisely the time when the complexity and extent of the critical incident was becoming apparent to the RCMP. In that moment, the information they shared contributed to the emerging picture. In his testimony, S/Sgt. Rehill identified the MacDonalds' call as the inflection point that increased his concern sufficiently to prompt his call to Acting Insp. Stephen (Steve) Halliday: "The real occurrence that made me think what is going on, we have something serious here, was when the MacDonalds call."[60] S/Sgt. Rehill also reflected that, at the time when the MacDonalds' call was inadvertently patched through to him, he was "juggling a lot of balls."[61] The IARD responders were entering Portapique, Mr. Brent was on the phone with AD, additional RCMP members were travelling toward Portapique from surrounding areas, and S/Sgt. Rehill was seeking to understand the reports that a marked police car was somehow involved in the incident while also contemplating the steps required to notify uniform command and to call out a critical incident commander (CIC) and the critical incident package.

With incomplete information about the details that had been provided by community witnesses, RCMP members were seeking to understand why an RCMP car had been mentioned. The possibilities considered in this period ranged from the question of whether an RCMP member was perpetrating these crimes, to the possibility that an RCMP vehicle had been stolen, to the possibility that witnesses had mistaken a decommissioned Ford Taurus from which the vinyl stripes and logo had mostly been removed or another kind of marked car for an RCMP vehicle. The speculation about whether the perpetrator might have been a police officer was seemingly sparked by a member's mention that Sgt. Lilly may have a cottage in the Portapique area. Other members, as they were driving toward Portapique and trying to understand the information they were hearing from dispatch, suggested that Ms. Blair may have mistaken another vehicle for a marked RCMP vehicle. Had the details provided by Ms. Blair and soon afterwards by AD and the MacDonalds been captured and analyzed, it would quickly have become obvious that several of these theories were far less likely than they initially appeared. For example, four community witnesses had each clearly stated that they recognized the perpetrator as their neighbour, provided his name, and said that he was not a police officer. This information made the possibility that Sgt. Lilly or another RCMP member was directly implicated far less likely.

Ms. Blair was categorical that the car was "decked and labelled" as an RCMP vehicle, and AD and Ms. MacDonald also provided information to support the proposition that the car was clearly marked. Had it been fully captured, this information should similarly have made the possibility that the vehicle was decommissioned and stripped of its markings, or that it was another kind of marked vehicle, correspondingly less likely. In addition to the two Blair children, two other surviving eyewitnesses – the MacDonalds – were available to answer further questions about what they had observed. This option too seems to have been overlooked for several hours. Mr. MacDonald was not interviewed until the following day, at 5:00 am on April 19, and Ms. MacDonald was not interviewed until April 20, the day after the perpetrator had been killed.

Unfortunately, much important information – including the availability of surviving adult eyewitnesses – was not captured in the incident activity log. In the absence of this information, speculation flourished and decisions were made by RCMP members who were relying on demonstrably incorrect theories about the perpetrator's vehicle.

RM Rehill called Acting Insp. Halliday at 10:35 pm on April 18 to brief him on the unfolding situation at Portapique. We have already mentioned that this call was precipitated by the information shared by the MacDonalds. In his testimony, S/Sgt. Rehill was adamant that he had advised Acting Insp. Halliday that the MacDonalds were surviving witnesses. Acting Insp. Halliday was equally adamant that he had no knowledge of any surviving witnesses until the IARD responders were debriefed at approximately 3:30 am on April 19. Either way, this important information was not conveyed to the CIC until the IARD responders were debriefed. Unlike RM Rehill, Acting Insp. Halliday did not access the incident activity log. S/Sgt. Allan (Addie) MacCallum was monitoring the incident activity log and Colchester radio. When asked in our proceedings how the information about surviving witnesses had been overlooked, S/Sgt. MacCallum testified:

> The amount of – amount of information and material that was in the CAD messaging was immense. Updates were coming from multiple callers.
>
> I don't know. And you know, I heard just through – organically through this process about, you know, some recommendations and one of them in my mind, and I can't see how it wouldn't be a great idea, would be to have some sort of review ongoing of information that came in to make sure that nothing got missed.

> Typically, on an average file, even if it's major, an NCO, a lead investigator, can skim through that material, a dispatcher, a risk manager, can skim through that material and see salient points fairly quickly if some get missed.
>
> This voluminous and, I mean, I got there, obviously, after – I got there around 11 o'clock, so over a half an hour after the MacDonalds had that encounter. I didn't hear it on the radio. I didn't hear – I didn't know that they were around. I don't know how it got lost.[62]

Similarly, S/Sgt. Allan (Al) Carroll testified that the information about the MacDonalds "didn't come from the OCC … None of us had any knowledge of it. And I can't explain why."[63]

RM Rehill and Acting Insp. Halliday agreed that they had discussed the fact that Sgt. Lilly might be involved in their initial phone call at 10: 35 pm. In his interview with the Commission, Acting Insp. Halliday stated that greater concern had arisen when Sgt. Lilly's name was mentioned. He said that RM Rehill had been clear in his initial briefing that eyewitnesses had described a "marked car" and that his immediate fear was the possibility that an RCMP member had committed the shooting.[64] From contemporaneous recordings, RM Rehill seems to have been similarly concerned by the possibility that Sgt. Lilly might be involved. In addition to directing that the OCC confirm the location of all known marked vehicles, Acting Insp. Halliday called Sgt. Lilly to confirm that he was not involved. In his Commission interview, Sgt. Lilly, understandably, expressed bewilderment at the initial suspicion that he had been involved:

> I was a little taken back that he thought that I would be postal enough to do something crazy like this. I don't know, but of course, if my name got mentioned he had to ask, of course. So, I have no idea where my name came from or how it got brought up. It makes no sense to me, and I've actually been trying to figure that out myself, where and how it came up.[65]

Sgt. Lilly's acknowledgement that the question of his potential involvement had to be investigated once it had been credibly raised is fair-minded and accurate.

Nonetheless, this line of inquiry captured the attention of two senior members of the critical incident response during the crucial early response period. These supervisors evidently did not recognize that the Sgt. Lilly theory was inconsistent with clear information provided by four community witnesses, each of whom

provided the perpetrator's first name and explained that they recognized him as a neighbour who was not a police officer. By this time, the perpetrator's full name had also been obtained from property records, which lent further plausibility to the community witnesses' information. This was not by any means the only theory being pursued at this time: other RCMP employees were searching the perpetrator's vehicle records, for example. Nonetheless, it was a distraction that could have been identified as an unlikely explanation, had the consistent information provided independently by community members been adequately captured and shared – or had these supervisors taken active steps to confirm what information had been provided by community members.

It quickly became evident that Sgt. Lilly was not in any way involved in the incident in Portapique, and that no marked RCMP vehicles from Colchester or Cumberland counties were unaccounted for. In his testimony, Acting Insp. Halliday reflected on how this information informed his understanding of what vehicle the perpetrator had been seen driving:

> [W]hen it was confirmed through me that [Sgt. Lilly] was not involved, I started thinking about other possibilities, given the fact that sometimes references to old police cars, or, you know, an RCMP car with decals sometimes, as I mentioned, the decals stay on there, so the glue sometimes stays on, so I just started thinking about other possibilities that may have transpired.[66]

Somehow, ruling out the possibility that Sgt. Lilly was involved in the incident paved the way to a belief on the part of the command group that community members had seen the perpetrator driving a decommissioned former police vehicle without decals or other features such as a light bar. This belief was reinforced by the IARD responders' observation of unmarked decommissioned police vehicles that were on fire at the perpetrator's properties in Portapique, and later by information provided by Cst. Nicholas (Nick) Dorrington that he had had an encounter with the perpetrator in which the perpetrator was driving a decommissioned police vehicle with reflective decals on the rear bumper. In a subsequent interview with the Commission, Cst. Dorrington compared that vehicle to an RCMP vehicle with "subdued markings" on it.[67]

In our proceedings, several members of the command group reflected on their reaction to seeing the photograph of the perpetrator's replica RCMP cruiser that was shared with the RCMP at about 7:30 am on April 19. Sgt. Andrew (Andy) O'Brien

and Acting Insp. Halliday both suggested that they had found it hard to imagine that a person could reproduce an RCMP vehicle so precisely. Sgt. O'Brien reflected:

> Prior to this event, I would not have believed that someone could create a replica police car to match an RCMP vehicle. I had seen situations where in the United States people had created replica police cars, but I would not have thought someone could come across the decaling, not accurate decaling, nor a light bar to create a vehicle, and even go so far as to put numbers on it. If you had asked me beforehand, I would have said that's not possible.[68]

RM Rehill recalled, "the photograph we saw [on the morning of April 19] shocked us all."[69] This belief that it was unlikely that anyone could produce such an accurate replica helps to explain the command group's shift to an assumption that the car described by community members must be a decommissioned police vehicle, perhaps with some residual reflective tape or residue from the removal of decals. In Chapter 2, we suggested that this assumption represented a failure to engage in grim storytelling – that is, the command group's failure to consider the worst-case scenario consistent with the information then available. The discussion in this chapter has added context to this conclusion: **because no one took active steps to review what community members had said, the command group was unaware that information had been shared by eyewitnesses that would have challenged their belief about the perpetrator's vehicle.**

Acting Insp. Halliday did not review the incident activity logs or listen to the recorded 911 calls to confirm the descriptions that witnesses had provided, and he did not task anyone else to review these calls. Nor did RM Rehill, or S/Sgt. Carroll listen to these calls. When asked about it in his testimony, RM Rehill explained, "I was monitoring the occurrence, not the phone call."[70] CIC Jeffrey (Jeff) West and S/Sgt. Kevin Surette similarly confirmed that they did not review the 911 recordings to ensure that they had all of the information from this source. Nor did they review the incident activity logs themselves, or seek information directly from RM Rehill or the staff at the OCC about what had been shared by community members and what was known about potential witnesses.

The belief that the perpetrator was driving an unmarked decommissioned police vehicle was inconsistent with the clear and consistent information that had been provided by community members. This belief shaped the ensuing critical incident response for more than eight hours. In these hours, the information that had been

shared by community witnesses – and the information that there were surviving adult eyewitnesses from whom more information might be obtained – was available to the command group, if an RCMP member or OCC employee had reviewed the 911 call recordings. We noted in Chapter 2 that information about the perpetrator's replica RCMP cruiser may have prompted the command group to reassess its belief that the perpetrator was still in Portapique. Kate and Andrew MacDonald, like other Portapique residents, could also have challenged the RCMP's assumption that Portapique Beach Road was the only drivable route out of Portapique. Indeed, Ms. MacDonald had already shared this information with Cst. Colford, who had in turn shared it by police radio. This important information, too, was lost.

Direct liaison between the CIC and a scene commander is required by national RCMP policy. The absence of a scene commander likely contributed to the fact that CIC West did not receive important information from the scene**. However, it is also noteworthy that the critical incident commander did not seek a briefing from the risk manager or anyone else within the OCC when he took command. Nor did he instruct any member of his team to review the information that had been provided by community witnesses. The chain of information being passed from call-takers to dispatch and the risk manager, from the risk manager to Acting Insp. Halliday, and from Acting Insp. Halliday to CIC West was a brittle one, and more information was lost at each step of this chain.**

Some of the gaps created by the lack of liaison between the critical incident commander and risk manager would have been filled if the CIC had liaised directly with the members on scene. S/Sgt. West testified that he had no conversations with the IARD responders prior to or at the time of taking command. He did not know what the last known sighting of the perpetrator was before he took command and was not aware that there were two surviving adult witnesses. Nor did he ask.

Acting Cpl. Beselt, Cst. Patton, and Cst. Colford had all spoken to the MacDonalds, knew some of the information they had shared about the perpetrator and his vehicle, and were aware that Kate and Andrew MacDonald were available to be interviewed as surviving eyewitnesses. Much of this information had been shared by police radio but was not captured in the RCMP's incident activity log. This information was not grasped by the team at the command post until the IARD responders were debriefed by Acting Insp. Halliday at approximately 3:30 am on April 19. Acting Insp. Halliday testified that it was from this conversation with the IARD responders that he learned of the MacDonalds' existence. Even then, these witnesses were not immediately interviewed.

This detailed account of the RCMP's failure to accurately record, share, and evaluate information provided by community members in the first minutes of the critical incident reveals patterns that are also reflected in other aspects of the critical incident response. We observed in this and other instances that are documented in Volume 2, What Happened, a tendency on the part of RCMP members to overlook the important role that community members can play by providing information that can help facilitate a critical incident response. For example, the information provided to the OCC by community members worried that their family members or friends may have been targeted by the perpetrator was not fully appreciated as providing potentially important clues to the perpetrator's movements and whereabouts. This information had value to the critical incident response, quite aside from its importance in terms of the RCMP's responsibilities to provide accurate and timely information to families and community members. Similarly, several eyewitnesses to the Shubenacadie cloverleaf incidents described seeing a second victim – Joey Webber – in the back of the perpetrator's replica RCMP cruiser. This information was not shared with responding members, and so Mr. Webber's body was not found by RCMP for some time after members first arrived at the scene.

Ms. Murray-Bates explained the communications operators at Toronto Police Communications Centre are trained to elicit the scene-specific knowledge that a 911 caller will possess in an environment that is likely unfamiliar to first responders:

> [I]t's about providing that information that's going to help the – help facilitate the response … I was thinking about questions that we ask, for example, inside of a building, what's the best access points? You know, if they're in – if you're telling me that the subject is in this room or this hallway, where does that lead? Where will it come out? Which side of the building? Which side of the building does the apartment face? Where does the balcony come out? Things like that that really provide insights for the officers as they're responding, to how to get to the location.[71]

Having reviewed the 911 call recordings for the duration of the critical incident response, we have concluded that the RCMP Operational Communications Centre procedures, software, and training do not equip OCC staff to elicit, capture, and share the information provided by civilians in the comprehensive manner that is necessary to facilitate an effective critical incident response.

Nor did OCC staff invariably take steps to protect the safety of callers. The MacDonalds' call is an example in which an OCC employee evidently failed to

recognize that community members were in direct danger. In another instance, a call-taker signalled that he planned to hang up on a terrified caller who had good reason to believe that the perpetrator was in her immediate vicinity. We emphasize that these shortcomings are organizational rather than individual, and that they appear to us to be a product of a lack of institutional attention being paid within the RCMP to best practices for emergency communications centres.

The RCMP produced an amended version of H Division's standard operating procedures to the Commission. In that document, the call-taker's responsibilities in the event of an active shooter situation are now described as follows:

> An active threat is when one or more subjects participate in a random or systematic shooting, or other violent action, demonstrating their intent to continuously harm or kill others. The subject(s) specific objective appears to be that of mass murder. These situations are dynamic and evolve rapidly, demanding immediate deployment of law enforcement to stop the threat and limit harm or loss of life to innocent victims. Important: There will be a substantial increase in call volume in a short period of time. Call takers need to filter calls quickly. With each call, you must determine that the incident is at the same location. It would not be unheard of for criminals or terrorists working in concert to attack more than one location simultaneously. **If call takers have a caller on the line that cannot see the subject of complaint, confirm that police are responding and disconnect to allow the next call through. This will continue until you have a caller with additional, valuable information. The sole goal of call taking during the critical time after the initial file is posted is to obtain information that is immediately valuable in ending the threat(s).**[72]

We have emphasized the last portion of this quoted passage because it warrants particular comment. This passage appears to us to be a mistaken extension of the central principle of IARD, which posits that armed responding members should move toward an active threat in order to seek to stop that threat from causing harm. In this respect, it is similar to the evidence we reviewed in Chapter 2 to the effect that every gun-carrying RCMP member should have been "in the hunt" for the perpetrator, to the exclusion of other activities.

Had this direction been in place and followed by Mr. Brent when he was speaking with AD, the children at the McCully home, when they were sheltering in Portapique without adults, would have been without even the support that could be

provided by a 911 call-taker. The updated directive has serious shortcomings and is predicated on the presumption that another caller will have eyes on the perpetrator and will be able to provide better information than the caller who has reached the OCC. This is a very dangerous assumption. Callers who had specific information about the perpetrator and who may have had up-to-date information to share – such as a photograph of his replica RCMP cruiser or information about his weapons – would also have been disconnected on the basis of the overly simple measure of whether they could then see the perpetrator. As the evidence makes abundantly clear, in the case of this mass casualty, for hours after the MacDonalds placed their call, no other caller could have offered more helpful information about the perpetrator. This policy also fails to place value on the principle of care for the caller that Ms. Murray-Bates articulated clearly in her evidence about the responsibilities of 911 call-takers. Seeking even less information from community members, and moving further from a compassionate approach to callers who may be injured or terrified, is the wrong approach for the RCMP to take.

Beyond the problematic nature of the assumption on which this direction is premised, it also fails to account for the priorities of life that govern an incident response. Other necessary tasks described by Ms. Murray-Bates – such as the OCC's role in gathering information about the number, location, and condition of those who may have been killed or injured; and the role that the OCC can play in advising those who are in danger about how to protect themselves – are negated by this direction.

LESSON LEARNED

911 call-takers play an important role in our community safety ecosystem. They not only capture and relay information from 911 callers for first responders but also play a crucial role in helping community members to stay safe.

Recommendation P.13

RESPONSIBILITIES TO 911 CALLERS

The Commission recommends that

(a) The RCMP Operational Communications Centre training and procedures should be amended to emphasize the ethic of care for 911 callers and the central role played by 911 call-takers in eliciting important information from callers and helping community members to stay safe and share information even when they are injured or terrified.

(b) The RCMP instruction to call-takers, issued after the April 2020 mass casualty, to end the conversation with callers who can't see a perpetrator during a critical incident response should be reversed in favour of a policy that gives equal weight to strategies for obtaining relevant information about all aspects of a critical incident including, for example, the location of injured community members and advising callers about steps that will help keep them safe.

A second pattern that repeats itself with respect to information management is RCMP members' tendency to prioritize immediate, somewhat individualized action over reflective, coordinated evaluation of information. In some instances, as when Acting Cpl. Beselt, Cst. Merchant, and Cst. Patton left the MacDonalds in Cst. Colford's care while they formed an IARD response and searched for the perpetrator, the decision to shift into action is consistent with RCMP policy and very much in keeping with the priority of finding and stopping an active shooter. Even here, however, there were small but important failures of communication. For example, Acting Cpl. Beselt and Cst. Merchant did not announce by radio that they were forming an IARD response or signal that they were leaving their last announced location. The presence of the MacDonalds and a second group of witnesses, the Faulkners, at the top of Portapique Beach Road was not fully conveyed to dispatch and the risk manager, and the task of obtaining information including names and contact details from these witnesses was not assigned. Prior to joining the IARD response, Cst. Patton spoke with the MacDonalds and the Faulkners, but he did not transmit identification and contact information for either of these groups of witnesses before moving into Portapique. This is another instance in

which the presence of a scene commander would likely have supported the overall response, because such a person would have been aware of these interactions and able to give direction to record and share information about these witnesses.

The gaps in reflective, coordinated evaluation of the unfolding incident at the command level are more significant. In Chapter 2, we found that the command structure was not clear before S/Sgt. West assumed command. In this chapter, we have identified breakdowns in communication and information sharing: between the risk manager and uniform command structure represented by Acting Insp. Halliday, S/Sgt. Carroll, S/Sgt. MacCallum, and Sgt. O'Brien; between the CIC and the OCC; and between the CIC and those on scene. We have related that none of those who acted in a supervisory role thought to review the 911 calls or take other steps to ensure that the information then available to the RCMP had been fully captured and appropriately factored into command decision-making. Every RCMP supervisor who testified emphasized the volume of information they were receiving, the number of matters competing for their attention, and the sheer scale of the work that faced them during the critical incident response.

In the absence of a clear, predetermined allocation of roles and responsibilities, gaps, duplication, and wasted time arose within the work of the RCMP command group. Two examples of gaps are the failure to assign a scene commander and the failure to immediately assign a member of the staff sergeant cadre or nominate an analyst to review and evaluate the information that was available to the RCMP. An example of duplication is S/Sgt. Carroll's interference in containment at a time when RM Rehill was actively focused on this task and S/Sgt. Carroll did not have a complete understanding of the instructions that had already been issued or access to the Computer Integrated Information and Dispatching System (CIIDS) mapping application. An example of wasted time is the time lost by S/Sgt. MacCallum when he had trouble finding a computer that would allow him to access CIIDS and Pictometry software so that he could evaluate the terrain around Portapique. Lacking strategic coordination, the work performed by the command group at Bible Hill detachment, while certainly well intended, made less of a contribution to the overall response than would otherwise have been possible. This in turn increased the burden on the risk manager. **While the lack of strategic coordination reflected the lack of standard operating procedures and appropriate training for these supervisors, it also reflects the tendency to prioritize action over analysis and strategic thinking that, we find, pervades the RCMP's institutional culture.**

An example of the devaluation of coordination, information, and analysis arises in the work of the critical incident commander, CIC West. RCMP policy indicates that the role of the CIC is analytical, strategic, and responsible for the coordination of resources. For example, the CIC is responsible for "command and control of … all related resources."[73] The CIC must ensure "that liaison is established and intelligence shared with support units," approve operational plans, conduct "appropriate briefings and debriefings," and approve "the release of information to the media."[74] While these responsibilities are discharged within a team structure, the policy assigns responsibility to the CIC. In his testimony, CIC West focused on the role that the CIC plays with respect to the Emergency Response Team and crisis negotiator, characterizing these roles and relationships as lying at the heart of the CIC's work. The aspects of CIC West's role related to information management received less emphasis. Regarding the command team's decision-making process, he testified:

> [O]ur decision-making process throughout those number of hours was based on what we knew at the time, and what we – and the majority of our information, we – would have come in, in those early hours of the incident, and then as that information's coming in through the night.

However, he did not take steps to ensure that he had as full a picture as possible of the information that had come via the OCC, or from those who were on scene before the Emergency Response Team arrived.

MAIN FINDING

By 10:30 pm on April 18, 2020, the RCMP had received information from numerous sources that the perpetrator was driving a replica RCMP cruiser that, to most observers, would be indistinguishable from a real RCMP vehicle. This information should have shaped the command decisions from that time forward.

The failure to recognize that the perpetrator had disguised himself in this way was a product of deficiencies in the RCMP's process for capturing, sharing, and analyzing information received during a critical incident response.

Other Information Management, Communication, and Coordination Challenges

Volume 2, What Happened, documents other challenges that arose during the critical incident response with respect to information management, internal communication, and coordination. In this section, we discuss four important examples of these challenges. We describe how each of these challenges arose, and evaluate their impact on the RCMP's critical incident response. These challenges relate to methods for tracking members' physical locations, the use and availability of mapping technology, member usage of the Trunked Mobile Radio 2 (TMR2) system, and access to air support.

Tracking Members' Locations

In April 2020, the RCMP's only means of tracking the physical location of members were via the Computer Integrated Information and Dispatching System, or CIIDS, when a member is in a marked RCMP vehicle and logged in to their mobile work station; or by having members advise dispatch or a supervisor of their position by radio or other means. Throughout Volume 2, What Happened, and in Chapters 2 and 3 of this volume, we documented the challenges that this limitation presented. Three important examples are as follows:

- the command group's hesitation to send a second IARD group into Portapique on the evening of April 18, because of concerns about the risk of a blue-on-blue incident (IARD responders are on foot, and so away from their vehicles);
- the unavailability in April 2020 of the android tactical assault kit (ATAK) cellphone app (which permits members to see one another's locations in real time); and
- the challenges that arose in tracking members' movements on the morning of April 19 during the pursuit or manhunt phase of the critical incident response.

Challenges in tracking member locations also arose in the June 2014 critical incident response in Moncton. Ret'd. A/Commr. Alphonse MacNeil described these problems in strong terms, and made a recommendation accordingly:

> One area where training, tactics and equipment shortcomings jeopardized the effectiveness of ERT operations was the inability of the [command post] to identify, track and map individual ERT personnel or vehicles on the ground, in real time. This lack of situational awareness was a huge tactical liability – commanders were unable to quickly coordinate and communicate the movements of ERT personnel in relation to the suspect. Incident commanders are required to provide "command" and "control" but they cannot effectively control what they cannot locate. This increases risk, especially, in wooded areas and in the dark where the risks of blue-on-blue contact, or the suspect breaking containment can have fatal consequences. There are hardware and related software applications available which would allow for the secure and continuous geo-tracking of ERT assets on the ground. These are presently being evaluated by the ERT program.
>
> 4.2 It is recommended that Geo-tracking technology for ERT be identified and introduced in a timely manner.[75]

In the critical incident response of April 2020, serious problems were caused by the lack of technology to track RCMP members. This constraint affected almost every aspect of the RCMP's response, from the coordination of member movements in Portapique on the night of April 18/19, to the OCC's capacity to track members during the pursuit phase in the morning of April 19. It also had spillover effects, for example, on the volume of radio traffic. The fact that only some RCMP vehicles could be automatically tracked via CIIDS – in particular, that Emergency Response Team and unmarked vehicles do not have a mobile work station and so cannot be tracked in this manner – made the coordination of a dynamic, high-speed critical incident response to a perpetrator driving a replica RCMP cruiser a Herculean task. Had RCMP members been able to readily and authoritatively determine the legitimacy of other members and their vehicles using the tools then available in the field, both the shooting of Cst. Chad Morrison and the Onslow fire hall shooting might well have been avoided.

LESSON LEARNED

Member tracking technology, and proper training in the use of that technology, improves both the effectiveness of a large-scale critical incident response and public and member safety during the response.

As noted above, the MacNeil Report recommendation addressed geo-tracking technology specifically for ERT members. Insp. Pharanae Croisetiere's affidavit regarding the implementation of MacNeil Report recommendations as at August 2022 states:

> [T]he RCMP examined options for Geo-Tracking technology. ATAK was selected during the pilot phase. The proof of concept for the situational awareness application ATAK has been completed. It was deployed to all ERT and PDS [Police Dog Service] across Canada within the RCMP.[76]

Although H Division ERT had participated in a pilot program involving ATAK, this technology was not available to H Division members on April 18 and 19, 2020, because the licence keys for the software had expired. An email appended to Insp. Croisetiere's affidavit suggests that ATAK will now be rolled out beyond ERT members to approximately 18,000 front-line general duty RCMP users by late 2023, "based on the most recent project schedule."[77] In final submissions to the Commission, the Attorney General of Canada assured us, "The issue with expired licenses or certificates that existed in April 2020 will not happen again. The production environment is now working on a stable platform."[78] We are pleased to have this assurance and, based on the evidence we have received, we believe that a universal rollout of ATAK will provide dispatchers, supervisors, critical incident commanders, and front-line members with far better awareness of the locations of RCMP members.

Nonetheless, we note that in 2014, the MacNeil Report stressed both the importance and the need for timeliness with respect to this recommendation. The RCMP has been criticized for being slow to implement recommendations. A relevant example is provided by the findings made against the RCMP after the Moncton incident with respect to offences under the *Canada Labour Code,* RSC 1985 c L-2. In the New Brunswick court decision of *R v Royal Canadian Mounted Police,* 2017 NBPC 06, Jackson PCJ held that the RCMP had been too slow to implement the

rollout of carbines to front-line members after this step had been recommended in a prior review of a critical incident. Judge Jackson concluded:

> [W]hen one looks at the bigger picture there is nothing to suggest that RCMP management, either at National or Divisional level, felt a sense of urgency to move the project along. If, as RCMP internal documents state, the status quo was unacceptable in relation to the known duty to ensure the health and safety of general duty members, management's actions in response to that duty do not demonstrate a resolve to address the issue in a timely manner.[79]

Judge Jackson specifically rejected an argument made by the RCMP that the rarity of critical incidents justified its delays in implementing the rollout of carbines:

> Front-line officers were left exposed to potential grievous bodily harm and/or death while responding to active shooter events for years while the carbine rollout limped along, apparently on the assumption that as the likelihood of such an event was relatively rare, a timely implementation was not required.[80]

The RCMP did not explain its delay in implementing the ATAK rollout. It is apparent from the evidence that H Division's Emergency Response Team had participated in a pilot project using devices enabled with ATAK. Cpl. Trent Milton of H Division ERT testified that this pilot project had been initiated after Emergency Response Teams in Nova Scotia and New Brunswick had advocated in the wake of the MacNeil Report recommendation "to try to get that up and running over the following years."[81] The H Division ERT was issued six Android devices running ATAK on a developmental server, which they used for some months. However, a few weeks before the mass casualty of April 2020, "the encryption key on these devices went down." Cpl. Milton testified that they sent the devices to Ottawa to be rekeyed but, due to the pandemic,

> nobody was at the office to receive them. So it was literally a month or more of going back and forth, trying to figure out where to send these devices, how to get them up and running, letting them know the urgency that we needed these devices back. And as of April 18th and 19th [2020], that still hadn't happened and we still didn't have our devices back in

> hand; and, therefore, we're basically blind as far as situational awareness went and mapping on the ground.[82]

Two days before the mass casualty, on April 16, 2020, Cst. Milton of the H Division ERT sent an email to numerous recipients in RCMP national headquarters seeking instructions about how to reactivate the ATAK devices. His email emphasized the importance of this technology: "I cannot stress enough the importance of getting these devices back online for us as quickly as possible."[83] In testimony, ERT leader Cpl. Timothy (Tim) Mills characterized the ATAK devices as "expensive paperweights … six brand new phones, and they were worthless at that point. They were just sitting on a desk."[84]

In Chapter 1, we quoted Dr. Bjørn Ivar Kruke's observation that "[i]n change, we see that learning is a priority."[85] In this instance, we observe that notwithstanding Ret'd. A/Commr. MacNeil's warnings about the cardinal importance of location tracking, and despite past criticisms of the RCMP for being too slow to implement change in response to concerns about member safety and the effectiveness of critical incident response, the RCMP moved too slowly to implement the MacNeil Report recommendation to adopt geo-location technology. This lack of urgency prevailed despite the best efforts of RCMP members to highlight the pressing need for this technology. In this regard, RCMP leadership failed its front-line members and the public, both of whom would have been better served in April 2020 if the RCMP had implemented a recommendation made in December 2014.

MAIN FINDING

Despite Ret'd. A/Commr. Alphonse MacNeil's warnings about the importance of being able to track member locations during a critical incident, the RCMP failed to implement the recommendation with respect to geo-tracking Emergency Response Team members in a timely manner. In this regard, RCMP leadership failed its front-line members and the public, both of whom would have been better served in April 2020 if the RCMP had then implemented a recommendation made in the December 2014 MacNeil Report.

Mapping Technology

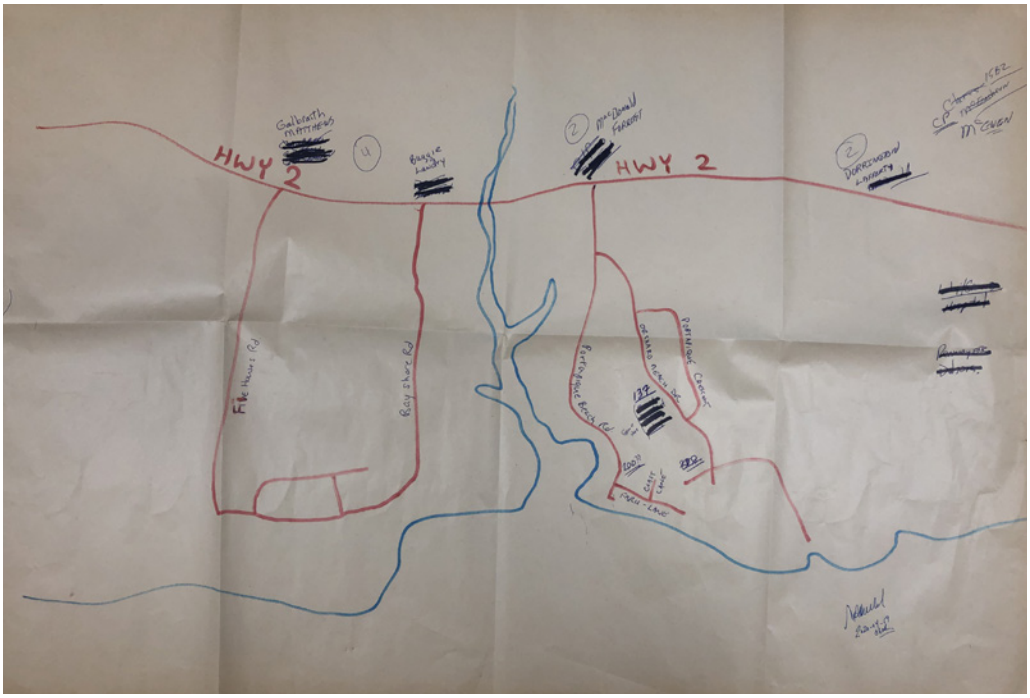
Between approximately 11:30 pm on April 18, 2020, and 1:25 am on April 19, Acting Insp. Steve Halliday, S/Sgt. Al Carroll, and S/Sgt. Addie MacCallum convened at Bible Hill detachment near Truro, to provide support to ad hoc incident commander RM Brian Rehill, prepare for the critical incident commander's arrival, and make sure they "were responding to this incident as efficiently and as effectively as [they] could."[86] Of these three non-commissioned officers, S/Sgt. MacCallum had the most experience with using the mapping software that was available to the RCMP. Acting Insp. Halliday assigned S/Sgt. MacCallum to work on maps of the Portapique area. S/Sgt. Carroll was also working with maps, as he was assigned to review containment measures.

In April 2020, the RCMP had three main forms of electronic mapping technology. First, maps are integrated into the CIIDS system used for OCC dispatch. A simpler version of these maps is available in the mobile work stations installed in marked RCMP vehicles; however, this version has less functionality than the version available to the OCC and supervisors. Second, the RCMP subscribes to a software program called Pictometry, which is accessed via an online portal. In order to have access to this program, RCMP members must complete a training course and obtain a user name and password. Third, RCMP members often accessed Google Maps or other publicly available mapping applications such as Bing Maps. In the OCC, RM Rehill and OCC supervisor Ms. Jen MacCallum were using all these applications to help orient themselves to Portapique and to coordinate the initial member response.

S/Sgt. MacCallum's home detachment was in Pictou, Nova Scotia. Working from the Bible Hill detachment, S/Sgt. MacCallum later related the frustrating experience of logging on to "six or seven computers" over the course of about 25 minutes to try to find one that had CIIDS software installed. He explained that he had previously understood that every RCMP computer should have "a certain standardized suite of software" including CIIDS, but that the general duty computers at Bible Hill did not appear to have mapping software installed.[87] (S/Sgt. MacCallum subsequently learned that outside the OCC, only supervisors' and administrative assistants' computers have CIIDS.) He finally found a computer that gave him access to CIIDS, which allowed him to see the location of RCMP vehicles with active mobile work stations. However, S/Sgt. MacCallum explained that CIIDS is less valuable than Pictometry for evaluating terrain. He looked for access to Pictometry on Bible Hill computers, but could not find it; nor was S/Sgt. Carroll (who

was based in Bible Hill) able to assist him. Eventually, S/Sgt. MacCallum relied on Google Maps to evaluate the terrain. He reflected that Google Maps is "not very good. It's making roads where there's no roads, as far as I can tell."[88] Eventually, he said, "I end up pulling a map off the wall. We put it on the table and start hand-drawing on it so that we all could be around it."[89]

Hand-Drawn Map of Portapique and Five Houses



A hand-drawn map illustrating the containment points set up along Highway 2 on April 18 and 19, 2020: COMM0011833

Neither S/Sgt. Carroll nor Acting Insp. Halliday had been trained in Pictometry. S/Sgt. Carroll couldn't use CIIDS. Acting Insp. Halliday testified that it had been some time since he had used CIIDS regularly and that "that technology has evolved, you know, significantly."[90] Similarly, CIC Jeff West did not have a laptop with him on the evening of April 18/19 and had no access to maps or navigation technology until the ERT technical support member, Cpl. Kevin MacDougall, was set up in the command post. When the command group convened at the command post, they worked on a hand-drawn map of Portapique and Five Houses, while consulting an atlas, a printed map, and the maps available via Cpl. MacDougall.

Pictometry Image of Portapique

Pictometry image of Portapique exported from the CONNECTExplorer application. Visible labels are added by the "labels" layer, within the application. Map data from April 2020–June 2020.
Map Data | Google, ©2023 CNES / Airbus

Acting Insp. Halliday testified that he did not task anyone with obtaining access to Pictometry. He recalled that at approximately 4:00 am or 4:30 am on April 19, he saw a map of the Portapique area terrain that was similar to the map that was available from Pictometry. He observed that the area of the blueberry field road may be traversable and that "was what drew [his] attention to the fact that maybe [they needed] to move some cars up into that area."[91]

The challenges S/Sgt. MacCallum experienced in obtaining access to adequate maps at Bible Hill detachment were understandably frustrating. We find it surprising that access to high-quality mapping software and training in the use of this software are limited resources within the RCMP. We agree with Acting Insp. Halliday that, had a member of the command group viewed Pictometry images sooner, the need for containment east of Brown Loop would have been apparent at that time. However, RM Rehill recognized the need for eastern perimeter containment and believed a member was providing that containment. Similarly, we note CIC West's evidence that he did not review containment when he took command of the critical incident response.

Ultimately, we conclude that the problems experienced by the supervisors at Bible Hill detachment and the command post's failure to identify gaps in containment were not significantly attributable to shortcomings in the availability or quality of the RCMP's mapping technology. Rather, the lack of clarity about roles and responsibilities and inadequate training and practice of front-line supervisors, documented in Chapter 2, were the primary reasons for the gaps that arose in containment.

MAIN FINDING

The gap that arose in the RCMP's efforts to contain a perimeter east of Portapique and the command group's failure to recognize that the blueberry field road provided an alternative route out of Portapique for a motorized vehicle were not materially caused by any inadequacies in the RCMP's mapping technology. H Division was inadequately prepared for a large-scale critical incident response in a relatively remote area of Nova Scotia. The uncertainty about roles and responsibilities, and the lack of training and preparedness of front-line supervisors, were the primary reasons for the gaps that arose in containment.

TMR2 Radio

Nova Scotia has a Trunked Mobile Radio 2 (TMR2) communications system that is maintained by Bell Mobility and used by the RCMP, municipal police agencies, and other emergency services providers. The RCMP uses encrypted channels and encrypted police radios on this radio system, and can also access unencrypted mutual aid channels when working with agencies that do not have access to encrypted devices. TMR2 was implemented in June 2015. The network is interoperable, incorporating a number of encrypted and unencrypted mutual talk channels that permit members from different agencies to communicate with one another. TMR2 radio communications permit RCMP members to communicate with one another and with dispatchers and supervisors. Such communications may be heard by anyone who has an encrypted TMR2 radio tuned to the channel on which members are communicating.

When a member has pressed the "transmit" button on their mobile car radio or portable body-worn radio and been given the opportunity to speak, no other communication will be transmitted on that channel while that person is speaking. Two exceptions arise to this principle. First, the OCC can "ruthlessly override" or speak over any communication except an emergency request to talk. Second, all radios have an "Emergency Request to Talk" (ERTT) button.[92] When pressed, this button overrides all other radio traffic. A loud alarm will sound via the CIIDS system to alert dispatchers and supervisors to the fact that the ERTT button has been pressed. In an interview with the Commission, Matthew Boyle, director of public safety and field communications in the Department of Service Nova Scotia and Internal Services, explained:

> [W]hen you press that, a whole bunch of things happen that are different than any other circumstance on the radio. If there's not a channel available on the channel site to process your call, when you ERTT, the system will actually bump an active user off the tower. It will interrupt an existing conversation in order to process your emergency. So as long as you can reach the tower, you will get through immediately, and that triggers a much more visible and audible alert to the dispatcher.[93]

The ERTT button also automatically puts the radio on "open mic" mode so that a user who has pressed this button can transmit information hands free.

Radios also have a "Request to Talk" (RTT) button. In the RCMP, members are instructed to use this button to signal that they want an OCC dispatcher to monitor the discussion on a given talkgroup. When the RTT button is pressed, it sounds a "chirp" at dispatch work stations in the OCC.

In normal operating conditions, the RCMP in Nova Scotia uses separate talkgroups for members in each county. For example, there is a dedicated Colchester radio talkgroup that is separate from the Cumberland radio talkgroup. However, any RCMP member with a radio has the capacity to listen or broadcast to any RCMP radio talkgroup, regardless of their physical location. One constraint on this principle is the capacity limits of TMR2 towers, most of which can carry traffic for up to only three channels at a time in rural areas. (Channels being used by other agencies will also count toward this total.) Given this constraint, RCMP members are discouraged from following a practice of having one radio tuned to one talkgroup and a second tuned to a different talkgroup. However, when necessary, the RCMP can "patch" two or more talkgroups together so that, for example, the radio traffic on Colchester talkgroup and the radio traffic on Cumberland talkgroup are merged.

The RCMP used this capacity during the critical incident response in Nova Scotia in April 2020.

Effective radio communication is a learned skill. The TMR2 user guide explains:

> The skills required are learned by listening, practicing and adhering to procedures, and honed by experience under all operating conditions. A good operator sounds good, knows how to operate correctly, and does so consistently. A poor operator, through lack of knowledge or attention, can disrupt communications with the misuse of procedures and prowords … and poor radio discipline.[94]

A proword is a phrase that has been assigned a specific meaning by an organization, to facilitate efficient communication. The phrase "10-4" is a commonly known example; it signifies that the speaker has heard and understood and/or that they will proceed in accordance with a direction. So, for example, early in the critical incident response on the night of April 18, as the first responding members were arriving at Portapique, Cpl. Natasha Jamieson asked the OCC to conduct a property search to learn more about the potential perpetrator:

> RCMP OP3: They say the SOC is [first name of perpetrator]. And it doesn't say what the last name is … It says, ah, the house was bought by him.
>
> CPL. JAMIESON: Can you do a property online check for that?
>
> RCMP OP3: 10-4.[95]

The RCMP also uses other "10 codes." The meaning ascribed by the RCMP to a given 10 code may be different from the meaning given to the same 10 code by a different agency. Chief Dwayne Pike of Amherst Police Department pointed out that these differences in agencies' 10 codes impede interoperability and can create risks to member safety: "If you don't understand what the other person is saying and what they mean, you could be going off in the complete opposite direction."[96] Chief Pike and Chris Davis, who is a former member of the military police with the Canadian Armed Forces, provided a vivid example of this problem:

> CHIEF DWAYNE PIKE: … I go to a scene and I say, "Hey, I'm 23 at the scene, and now I'm leaving the scene, I'm 24, 10-24."
>
> …

> MR. CHRIS DAVIS: 10-24 for me is a gun. So if you say "10-24" things are –
>
> CHIEF DWAYNE PIKE: Exactly.
>
> MR. CHRIS DAVIS: – ramping up real fast.[97]

It is a fundamental premise of effective radio communications that a person conveying information should listen for acknowledgement of that information, and that a person who hears information relevant to them should confirm receipt of a transmission. We noted above that Ms. Murray-Bates explained in her evidence that at the Toronto Police Communications Centre, dispatchers are trained to support members' radio communications by, for example, repeating information of general importance after it has been shared by a member in order to "make sure that everyone else that needs to hear it hears it."[98] This practice was not consistently adhered to by RCMP dispatchers and supervisors during this critical incident response. Nor did members always use the RTT button before addressing dispatchers by radio. Consequently, critical information was lost, delayed, or not acted upon.

These lapses in radio protocol may well have contributed to the loss of information that we have documented in this chapter. For example, at 10:35 pm, Cst. Vicki Colford pressed RTT before saying, "There's a white Hyundai, I'm just with one of the victims here. Um, going back towards town on the number 2. I'm not sure who that is."[99] Her transmission was not acknowledged by dispatch. She repeated this transmission at 10:37 pm, at which time Cst. Aaron Patton responded, "Yes, copy Vicki. I was talking to him. Ah, it's not the SOC."[100] As we explained in Volume 2, What Happened, this car was the Faulkners' vehicle. The failure to acknowledge Cst. Colford's initial transmission, which, based on all information available at that time, could well have been a sighting of the perpetrator, is a striking omission. Approximately 10 minutes later, when Cst. Colford transmitted information about a potential alternative route out of Portapique, she addressed her transmission to Millbrook members rather than to dispatch. Again, her transmission was not acknowledged. This time, she didn't repeat the information.

Cst. Adam Merchant, who was an IARD responder in Portapique, told the Commission that at this stage of the critical incident response, there was "too much radio chatter" from supervisors: "you don't have to say things that are very obvious."[101] He provided an example of an instance in which, in his view, members of the command group who were not on scene were insufficiently attentive to the radio transmissions of members on scene. In this passage, his reference to "the guy in the woods" is a reference to the encounter between Clinton Ellison and the IARD

responders, in which the IARD responders believed Mr. Ellison to be the perpetrator after seeing his flashlight in the woods:

> [W]hen we had the guy in the woods, I saw the radio transmissions and like, we got a guy in the woods, possible suspect, and they're asking everyone to call out their car signs and stuff. And I don't even remember that happening, but like, there's a time and a place for that.[102]

The problem Cst. Merchant points out here is that, at a time when the IARD responders had radioed that they believed themselves to be in direct proximity to the perpetrator and therefore at immediate risk of engaging an active shooter, a supervisor took precious radio time for a roll call that was not immediately time sensitive.

A second example of ineffective radio communications occurred at the Onslow fire hall shooting. Cst. David (Dave) Melanson explained that before he and Cst. Terence (Terry) Brown opened fire, he tried repeatedly to use his radio:

> I made several attempts at that point to get out on the radio, on the car radio to tell – to let people know what we were seeing, and I couldn't get through. The radio was bonging. And then when I couldn't get through there, I grabbed my carbine, and [Cst.] Terry [Brown] had gone out the side door, and I went to the back, back of the car. I went to the back of the car, and at that time I was, again, down, trying to get out on the – on the radio with my portable.[103]

The RCMP provided a "subscriber rejects report" for the period of the critical incident response.[104] This report confirms that Cst. Melanson repeatedly tried to use his radio to transmit at the time of the Onslow fire hall shooting. Mr. Todd Brown, director of strategic initiatives at the provincial office of public safety and field communications explained that a transmission will be rejected if the radio channel is busy or the tower does not have an available channel for transmission. We noted in Chapter 2 that, at the time of the Onslow fire hall shooting, the Colchester radio channel was extremely busy as RM Briers was directing members to take up strategic positions across a wide area from Cumberland to East Hants counties. At that time, the Emergency Response Team was also still using the Colchester radio talkgroup to communicate with one another. Many inaudible or no audio transmissions are also recorded in the transcript at around this time. A "no audio" transmission

arises when a member intentionally or accidentally presses their talk button but does not speak.

Three issues arise from this course of events. First, the RCMP had not planned how best to use radio for a critical incident response of the scope and scale that played out on the morning of April 19, 2020. Ad hoc decisions about how best to manage the volume of radio transmissions while ensuring that all members had vital information were an inadequate substitute for training and preparation. In our roundtable discussions, the chief of the Amherst Police Department, Dwayne Pike, offered that his service has found an alternative approach:

> [F]or our fifth [TMR2] channel, we ended up using something we call "Announce", so that our dispatch can, at any given time, just go on to that channel and make some kind of an announcement that goes across all the other channels. So in the case of a critical incident or something like that, regardless of what channel you're on, or whether you were just doing regular duties, or maybe you're in training, they can come out and say, "Hey, we've got this going on" and everybody knows what to do and how to respond.[105]

This may not be the best approach for the RCMP, but the point is that a proactive approach is necessary to avoid the situation in which a critical incident commander or risk manager is seeking ad hoc solutions. **At a time when the service is not responding directly to a crisis, forethought should be given to how best to manage radio channels during a large-scale critical incident.**

A second issue that arises from the morning of April 19 is that the pressure on airtime was increased by wasted transmissions. It is unclear why so many of the transmissions, from many different members, were inaudible or no audio, but this is essentially wasted airtime and it created safety issues for police and the public. These are questions for the RCMP to study and address.

Finally, we note that the ERTT button is intended for the very situation in which Cst. Melanson and Cst. Brown found themselves at Onslow. They thought that they had eyes on the perpetrator. A radio transmission would have been an appropriate way to confirm whether the RCMP vehicle parked outside the Onslow Belmont Fire Brigade hall was genuine. Cst. Melanson testified that he did not consider using his ERTT button, partly because it "would have took my mind and my attention off of what was important at the time to try to find that" button on his radio.[106] He noted

that his hard body armour may also have been an impediment to reaching his radio. Cst. Melanson was not the only member who experienced difficulties with the interaction between his radio and hard body armour. As Cst. Patton was arriving in Portapique on the night of April 18, his hard body armour repeatedly pressed his RTT button. This prompted an exchange in which Cst. Patton advised dispatch to ignore his RTTs. This, too, raises concerns about member safety.

Given the circumstances in which an ERTT button is likely to be required, reaching this button – and remembering to use it – should be a reflex action for any member. In a roundtable, William (Bill) Moore, who is the public safety project lead at Halifax Regional Municipality and a former deputy chief of Halifax Regional Police, observed that he worries about how well all police agencies train their members in the use of the TMR2 system and equipment:

> We have a lot of good material, but is that material and the training getting down into the hands of the person that's responding at 2:00 in the morning with someone that they'd never met before from another – and that's just police to police.

Members receive training in the TMR2 radio when they arrive in H Division and every four years thereafter. Cst. Melanson's evidence that the ERTT button was not easily and immediately accessible suggests to us that either training with that button or the design of the radio and uniform – or both – are insufficient to equip members to make use of that button in the inherently stressful circumstances when it will be needed. If a member has to use the ERTT button, they will by definition be facing an immediate threat. Stress can compromise fine motor skills, and so muscle memory becomes especially important in this moment. In this regard, we also note that the RCMP's outdoor IARD training does not incorporate the use of radios, but some police agencies routinely incorporate radios – and communications difficulties – into their training scenarios. We heard much evidence that training time is precious, and the failure to incorporate communications into IARD training represents a significant missed opportunity to give RCMP members experience using their radios while under somewhat realistic and stressful conditions.

In final submissions, the Attorney General of Canada stated that "the RCMP has instituted additional training for all members on the TMR2 radio system" with the aim of ensuring that members "have a clear understanding of ways in which they can ensure important information broadcast over the radio has been received by those in command."[107] Responding members were more likely to identify unhelpful

or poorly timed supervisory directions as being a frustration, and we have also pointed to problems with dispatchers' radio use. Nonetheless, this is likely a helpful initiative. However, as the Attorney General of Canada notes, "[t]here is more that can be done."[108] **Addressing the problems that arose with radio use during the critical incident response requires a holistic review of radio training for members, supervisors, and dispatchers; advance planning for management of radio communications in large-scale critical incident responses; and an evaluation of radio and uniform design to ensure that the ERTT button is accessible when needed.** It is also important for RCMP leadership and supervisors to emphasize good radio practices in ordinary circumstances, as habitual attention to radio communication will ensure good practices are instinctive when members encounter dangerous or stressful conditions.

LESSON LEARNED

Effective radio use is important at all times, and essential during critical incident response. Police agencies should emphasize the importance of following radio protocols, and should have plans in place for managing radio communications during large-scale incidents.

Recommendation P.14

EFFECTIVE USE OF POLICE RADIOS

The Commission recommends that

(a) The RCMP should

(i) commission and publicly share an international evaluation of best practices in radio transmission and incorporate the results of this evaluation into its training, policies, and practices;

(ii) conduct a holistic review of radio training for members, supervisors, and dispatchers, including the means by which changes in policy, procedure, and equipment are communicated and implemented;

(iii) prepare plans for managing radio communications during large-scale critical incident responses;

(iv) evaluate radio and uniform design to ensure that the Emergency Request to Talk (ERTT) button is accessible when it is needed; and

(v) incorporate radio use and challenges with radio communication into scenario-based and tabletop training.

(b) RCMP leadership, supervisors, and Operational Communications Centres should

(i) emphasize effective radio use and adherence to proper radio protocols at all times to ensure that good practices are routine; and

(ii) conduct an annual assessment of division-wide compliance with training and policy.

IMPLEMENTATION POINTS

- RCMP radio protocol should
  - require that the speaker identify themselves by name, rank, and role if relevant; and
  - identify the intended recipient of the transmission, deliver the message, and await confirmation of receipt by the intended recipient.
- Any upgrades to radio technology should be accompanied by member-wide training and practice.

Air Support

RCMP Air Services is a federal service for which Nova Scotia pays a contribution under the RCMP Provincial Policing Services Agreement. Air Services for the Atlantic provinces is headquartered in Moncton, New Brunswick. In April 2020, the services included a helicopter and a fixed wing aircraft. On April 18 and 19, neither aircraft was available due to scheduled maintenance, and no alternative plans for air support had been made. Indeed, the RCMP Atlantic helicopter was unavailable for approximately six weeks around this time. We heard from RCMP H Division

witnesses that air support was frequently unavailable to the RCMP in Nova Scotia, for a range of reasons including limitations on the number of pilot flying hours, maintenance, and other duties performed by RCMP Air Services.

The importance of air support to an effective critical incident response was explained by Ret'd. A/Commr. MacNeil in his report on the response in Moncton in June 2014:

> The tactical application of air support (be it manned or unmanned) and electronic surveillance is now common practice for these types of operations to enhance officer safety. Having an aircraft overhead to search large areas of terrain for the heat signature of a suspect, with the capability of accurately and safely direct[ing] teams to the suspect's location, is a significant tactical advantage. Should the suspect move, this information is available in real-time and the team can redeploy accordingly. An aircraft can pin down a suspect who knows that his movements are visible from above, night or day. Someone can hide their thermal signature, but they cannot move about while doing so and are thus immobilized.[109]

In addition to finding that air support enhances the tactical response, the MacNeil Report emphasized that aerial surveillance mitigates the risk to which RCMP members are exposed during a critical incident. Both fixed wing and helicopter air support were engaged in Moncton, from both RCMP Air Services and Transport Canada. Ret'd. A/Commr. MacNeil found that they were important to the location and arrest of the perpetrator in that instance:

> [T]he suspect's heat signature was seen on the Dash-S's FLIR [Forward-Looking Infrared Technology, or thermal imaging]. The signature was located in a wooded area to the south of 21 Mecca Drive, underneath a series of power lines. The actions of the suspect were consistent with him hearing the helicopter depart, waiting to confirm it was actually gone, and then emerging from hiding in an attempt to change locations. The movement of nearby ERT personnel on the ground was coordinated from the Command Post in an attempt to isolate and contain the suspect … [An ERT member] issued an order of, "come out with your hands up!" The suspect replied, "I give up, don't shoot!" He left his firearms behind and came out of his hiding place with his hands up. Members quickly confirmed that they had arrested [the perpetrator].[110]

Ret'd. A/Commr. MacNeil recommended that the Emergency Response Team receive proper training and equipment to maximize the tactical advantage of aerial surveillance, particularly in nighttime operations. He also recommended that an appropriately trained air services liaison be embedded within the command post during critical incident responses "to offer advice to the incident commander" and ensure "that equipment and personnel [are] used in an effective and coordinated manner."[111] Ret'd. A/Commr. MacNeil also made another recommendation with respect to the FLIR equipment on the RCMP helicopter, which was then outdated. Insp. Croisetiere's affidavit indicates that these recommendations have either been implemented, or that they are in the process of being implemented to the extent resources allow. None of these recommendations address the availability of air support when needed. Rather, they are predicated on the assumption that it will be available when necessary to a critical incident response.

After it became apparent that the RCMP Atlantic aircraft were unavailable, OCC employees and members of the command group, including RM Rehill and Acting Insp. Halliday, made efforts to find alternative air support. These efforts continued on the morning of April 19. We found in Volume 2, What Happened, that the RCMP's lack of preparation and contingency planning for air support to be provided when RCMP Air Services are unavailable in the Atlantic region created a distraction for OCC employees and command. Acting Insp. Halliday testified that he received no guidance from the district policing officer or H Division executive leadership about how to find substitute air support. **The search for an alternative helicopter diverted the command group from other important tasks.**

It is difficult to assess the potential value of air support to the overall effectiveness of the RCMP's critical incident response. Based on the capabilities described by Ret'd. A/Commr. MacNeil, we find that air support had the potential to have a material impact. On the night of April 18/19, FLIR-equipped air support would have assisted responding members to locate Lisa Banfield and Clinton Ellison in the woods in Portapique. It might also have indicated that the perpetrator was not hiding in those woods, and would have provided IARD responders and Emergency Response Team members with support as they conducted ground searches. This *might* have assisted the command group to recognize the need to plan for the possibility that the perpetrator was elsewhere; however, in this scenario, the command group's theory that the perpetrator had taken his own life would not have been challenged. Air support would not have remedied the shortcomings in critical incident decision-making and preparedness that we documented in Chapter 2. Similarly, if properly trained and equipped air support that was well integrated

into the command post had been available on the morning of April 19, when the critical incident response went mobile, it would likely have been of assistance in locating the perpetrator at or near Glenholme and tracking his movements across Nova Scotia. **Air support might have resulted in the earlier interception of the perpetrator by RCMP members on the ground, but this possibility would have been maximized only by systematic preparation, training, and coordination.**

We obtained considerable evidence on the location and capacity of other air support resources in the Atlantic region and other RCMP Air Services resources in Quebec and Ontario. For example, the Joint Rescue Coordination Centre in Halifax maintains aircraft for search and rescue purposes, and Transport Canada maintains a fixed wing aircraft in Moncton. The RCMP received assistance from the Nova Scotia Department of Natural Resources on the morning of April 19, 2020; however, this helicopter and pilot to assist the critical incident response was not available until 6:00 am and their helpfulness was otherwise limited by several constraints. S/Sgt. Kevin Surette testified that "the pilot was fabulous. And, I mean, they came out to help us at a moment's notice … But the setup clearly is not ideal."[112]

The RCMP had memoranda of understanding in place with some other potential providers of air support. Some witnesses explained approval processes that must be followed to obtain assistance from other agencies in law enforcement incidents including, in one instance, a rule that the provincial solicitor general must contact the federal minister of public safety, who then forwards a request to the minister of national defence. These processes were unknown to the command group and to H Division's executive leadership on April 18 and 19, 2020.

In final submissions, the Attorney General of Canada stated that the RCMP has now put contingency plans in place for circumstances in which RCMP Air Services are unavailable due to maintenance. We have reviewed these submissions and an associated document produced by C/Supt. Michael O'Malley about steps taken in response to the mass casualty. Where RCMP services are not available, the OCC has now been given contact information for the Joint Rescue Coordination Centre and Air Services at the Nova Scotia Department of Natural Resources and Renewables. It appears to us that the steps taken by the RCMP since April 2020 may result in better availability of air support, but they do not alleviate the burden placed on initial critical incident commanders and the OCC to cast around for alternatives, nor do they address the uncertainty about whether non-RCMP resources will be made available. For example, C/Supt. O'Malley's document notes that "any after-hours urgent requests could still pose an issue for finding an available pilot"[113] and that "generally Air Services personnel are not on shift or on call

[after hours] so they may not be able to assist with alternative arrangements."[114] C/Supt. O'Malley also reports that "[e]ach air base has a different process" and that where after-hours support is provided, "it is on a voluntary basis."[115] In this context, we underscore Commissioner Gjørv's observation that "both civil protection and emergency preparedness require that the country's aggregate resources be utilised efficiently."[116]

Critical incidents do not arise on a 9:00 to 5:00 schedule. As C/Supt. O'Malley observes, providing air support for law enforcement purposes "is the intended mission" of the RCMP Air Services program. **The RCMP should establish a comprehensive contingency plan to ensure the availability of air support resources whenever these resources are needed. We stress that, in our view, this plan should not require the RCMP to procure additional aircraft, but that it can be accomplished through strategic partnerships with other federal and provincial agencies and possibly with the addition of pilots to the existing RCMP Air Services program. It is imperative that initial critical incident commanders and risk managers are able to activate air support resources, when needed, with a single call.** The responsibility of casting about to find ad hoc alternative sources of air support should never be left to risk managers or critical incident commanders while they are managing a critical incident response. This may mean, for example, that the call for air support is always made to the RCMP National Operations Centre, which manages resources from that point forward.

LESSON LEARNED

Police agencies should proactively establish arrangements for air support, including backup plans. Air support providers should be included in critical incident training.

Recommendation P.15

AIR SUPPORT

The Commission recommends that

(a) The RCMP should establish partnerships with other agencies to ensure that air support is available whenever necessary to a critical incident response. These agencies should be included in future training and preparation for critical incident response to ensure that they are able to provide the support required.

(b) The RCMP should adopt a single air support call-out process, to ensure that initial critical incident commanders do not waste time and attention looking for alternative sources of air support.

Working with Others

The RCMP was not the only organization that played a role in the critical incident response of April 18 and 19, 2020. Other police services, including the Halifax Regional Police and the Truro Police Service, were directly involved in the response. Emergency Health Services employees provided medical services and transported survivors to hospitals. The Colchester East Hants Health Centre provided medical care to those who were injured. Volunteer fire brigades also responded in a range of ways, including by providing premises for the command post and a comfort centre, attending crime scenes, and putting out fires set by the perpetrator. The Nova Scotia Department of Natural Resources supplied air support. The Colchester Regional Emergency Management Organization and the Nova Scotia Emergency Management Office played a role, as did Valley Communications. Media were actively engaged and seeking to report on the incident, including the danger posed by the perpetrator to the public in Nova Scotia. Many more agencies were engaged after the critical incident response had ended, for example, the Medical Examiner Service of Nova Scotia, the Nova Scotia Department of Justice Victim Services, funeral homes, cleaning services, and tow truck drivers.

In Chapter 1, we explained that interoperability is a key principle of effective critical incident response. Successful interoperability requires trusting relationships in which agencies understand one another's roles and responsibilities. Chief Pike explained this requirement well:

> [I]t's those relationships that are our core. Making sure that you have that trust and that ability to know how are the other agencies going to respond, and knowing that they know how we're going to respond.[117]

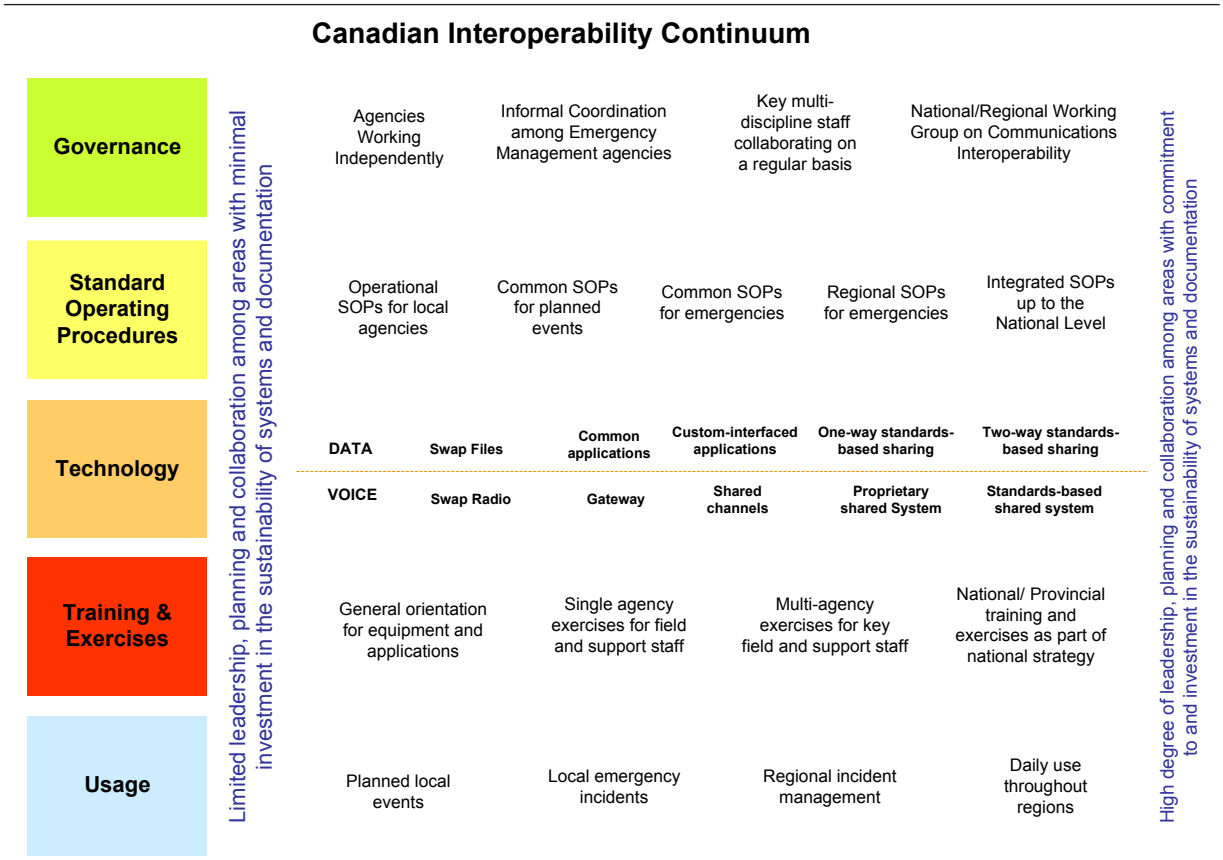
Or, as the RCMP's OCC commander for Prince Edward Island, Darryl Macdonald, explained it, "when it's the worst day ever, you need friends. You need help. You need support."[118] In Chapter 1, **we defined interoperability in critical incident response as the capacity of different emergency response agencies to work together during a critical incident. Other definitions exist, many of which emphasize the centrality of effective interagency communications to interoperability.** Interoperability also requires role clarity between agencies: "role ambiguity in time of serious emergency is crucial to avoid."[119] Cultivating effective interoperability requires an organizational investment in understanding other agencies:

> [Y]ou kind of have to walk a mile in someone else's shoes to be able to get it, and that takes time. It takes relationships, it takes questioning and answering, it takes exploring things that are uncomfortable.[120]

Trusting relationships and interoperability have been shown to enhance the effectiveness of critical incident response. In the Orlando Pulse nightclub review, the authors identify the following lessons learned:

> **Response to and management of critical incidents are greatly enhanced when pre-existing relationships exist between leaders and supervisors from all potential first responder agencies. Each leader involved in the response indicated that pre-existing relationships and trust amongst leaders enhanced decision-making, identifying steps that needed to be taken, allocation of resources, and delineation of roles and responsibilities for each agency.**
>
> Mutual trust and respect between agency leaders and command personnel within and across agencies, along with trust among line-level personnel working toward a unified goal, are overarching components for reducing competing interests and ensuring a collaborative response.[121]

In a technical report prepared for the Commission, Chris Davis, Cheryl McNeil, and Peter Gamble explain that efforts to enhance interoperability in Canada are "frequently constrained by a lack of joint planning and procurement, a lack of joint standard operating procedures, insufficient training opportunities, and resourcing challenges."[122] A body that formerly worked to enhance interoperability in Canada, the Canadian Interoperability Technology Interest Group (CITIG), was governed by the Canadian Association of Chiefs of Police, Canadian Association of Fire Chiefs, and Paramedic Chiefs of Canada "with a mission to improve Canadian public safety interoperability … through collaborative efforts, innovation and leadership." However, Davis and colleagues report that this body ceased operations in 2020.[123] Public Safety Canada and partners built on the work of CITIG to produce a communications interoperability strategy in 2011. This strategy includes a "communications interoperability continuum."[124]



Source | Public Safety Canada, "Communications Interoperability Strategy for Canada" (2011), Annex 1.

The Canadian Communications Interoperability Continuum identifies five aspects of interoperability, and for each aspect, defines a spectrum from "limited leadership, planning and collaboration among areas with minimal investment in the sustainability of systems and documentation" to "high degree of leadership, planning and collaboration among areas with commitment to and investment in the sustainability of systems and documentation."[125] In a roundtable, Lance Valcour, who is a retired inspector in the Ottawa Police Service and the former executive director of CITIG, emphasized that it is not necessarily the aspiration for all agency relationships to operate at the most interoperable end of this spectrum. As he explained:

> If you're only going to work together once every – you know, once a year, well then just, you know, arrive at the scene, swap radios or chat and do you what you have to do, move on.[126]

However, **Mr. Valcour emphasized that for critical incident response, interagency communications, roles, and responsibilities must be well understood in advance: "we need to operationalize it and train with it so that on the day, the worst day – the worst day of our lives – it all works."**[127] **Mr. Davis explained that building trust is easier when relationships are facilitated by guiding policies and procedures: "we have to work way too hard to build trust in the absence of clear policies, procedures, guidance, and obligations."**[128]

In Canada, the responsibility for championing communications interoperability lies primarily with a federal / provincial / territorial body of Senior Officials Responsible for Emergency Management (SOREM), which lies in turn under the purview of a group of federal, provincial, and territorial ministers whose portfolios include emergency management. Notably, SOREM does not include municipal representatives or Indigenous governments. These omissions are significant because many day-to-day emergency management and community safety services, including policing services, are primarily delivered by municipalities and Indigenous governments.

Mr. Valcour explained the overall goal of enhancing interoperability with respect to information sharing among agencies:

> Where we need to be is moving from the need to know to the need to share. So the starting ground should be everything should be shared, whenever possible, as quickly as possible, with the … people that really need it.[129]

Mr. Macdonald, commander of the OCC on Prince Edward Island, identified motivation as the greatest impediment to information sharing: "[W]ill is the biggest issue. The will of agencies to say I need to be able to share information outside of my agency."[130]

In Volume 2, What Happened, we made several findings related to interagency communications and protocols during the critical incident response of April 18 and 19, 2020. For example, in Chapter 4 of that volume, we concluded:

> The lack of shared RCMP, Emergency Health Services (EHS), and firefighter protocols to ensure that non-police emergency responders are safe and able to perform their work created an uneven response in which these responders were at times exposed to greater safety risks and at other times may have been prevented from doing work that would have aided the critical incident response or subsequent investigation.

And also:

> The RCMP did not systematically share information with other emergency responders, including volunteer fire services and Emergency Health Services, that would have permitted these responders to evaluate risks to their safety and take measures to better protect themselves.

An after-action report prepared by Emergency Health Services notes that EHS was not briefed in a timely manner about the incident to which paramedics were being dispatched. From the time when paramedics were first dispatched to Portapique (10:04 pm on April 18) and throughout the night of April 18/19, 2020, "there was no mention or use of the term 'active shooter'" in RCMP communications with EHS dispatch and supervisors.[131] The RCMP command group requested that an EHS supervisor attend the command post at Great Village, but this person was "locked out of police EOCs [Emergency Operations Centres] and command posts."[132] The EHS after-action report explains:

> This meant that information had to be funneled through the three agency communications centers (RCMP Telecoms, Halifax Regional Police Department Integrated Emergency Services, and EHS MCC). This highlighted a lack of unified command.[133]

Chief Larry Kinsman of the Great Village Fire Brigade also remained outside the command post, which was staged in his brigade's fire hall.

Unified Command

A unified command, in which responding agencies are co-located within a command post, is a common recommendation of critical incident reviews.

The review of the Orlando Pulse nightclub incident concluded:

> Greater emphasis must be placed on ensuring that unified command includes agencies outside of law enforcement, including fire, EMS [Emergency Medical Services], and other critical agencies, to ensure a multidisciplined response and the use of all public safety assets and capabilities as soon as practical during a critical incident.[134]

Accordingly, the report authors recommended:

> As soon as possible and practical during an incident, establish a unified command of all primary first responders – including fire and EMS – to facilitate communication, situational awareness, operational coordination, allocation of resources, and delivery of services.[135]

Asking EHS and Fire Brigade Command to wait outside the command post was out of step with best practices in critical incident response. The decision to exclude these key community safety partners created communication barriers that impeded the response. Police agencies must cultivate trusting relationships with EHS and Fire Brigade Command as these agencies work closely together. Excluding these agencies from the command post also deprived the RCMP of opportunities to obtain information from them. For example, Chief Kinsman and his colleague Bass River Fire Chief Alfred Grue, who was also staged at Great Village, knew the Portapique area far better than any member of the RCMP who was present in the command post.

The first time that EHS management was notified by the RCMP that the perpetrator remained at large was at 6:12 am on April 19, when some critical care paramedics who were ending their shift were debriefed by their manager. The EHS after-action

report also records receiving contradictory information about scene security from different members of the RCMP. The EHS was not notified that the perpetrator was no longer a threat until 12:46 pm on April 19, more than an hour after the perpetrator had been killed. Many of these issues would have been seamlessly resolved had EHS had a representative in the command post.

We conducted small group sessions with EHS paramedics and volunteer firefighters, in which these first responders reflected on their experiences during the mass casualty. Paramedics Melanie Lowe and Jeff Aucoin were dispatched to Portapique soon after the first 911 calls were received on April 18, 2020. They were initially asked to stage at Montrose Road, immediately across Highway 2 from Portapique Beach Road, which Mr. Aucoin characterized as

> way too close … We should never have been sent there…. Because – but we didn't know, right, we were told it was safe to go or we were requested by police. So – and usually when we're requested by RCMP it is safe to proceed.[136]

They fell back to a place near "a big blueberry field" before realizing that they were still "sitting ducks."[137] Eventually, they moved back to the fire hall at Great Village. While acknowledging that the RCMP responders did their best to respond in a difficult situation, Mr. Aucoin reflected:

> [W]e always want to help them, they always want to help us. That's how we work. And I think just that point, they were just worried, they were just trying to help those people that they could at that point, and they just wanted to get those people out and safe as quickly as possible. But at the same time, I think we were put in a position of danger, which we shouldn't have ever been put in, because we have nothing. We have no bullet proof vest; we have no weapons. Right? We have nothing.[138]

For at least 90 minutes after the first EHS paramedics were dispatched to Portapique, they received no direction about where to safely stage.

EHS paramedics were not told that the perpetrator might be disguised as a police officer. At the outset of the critical incident response, this omission likely reflected the confusion and disbelief that prevailed among the RCMP command group about the information that had been shared by community members. By 8:30 am on April 19, the position was quite different. By that time, the RCMP had received a

photograph of the perpetrator's replica RCMP cruiser and shared that information with its own members and with other police services. EHS dispatcher Bruce Cox told the Commission that the RCMP shared information about the perpetrator's disguise with EHS supervisors at about 8:30 am, but told them not to share it with dispatchers or paramedics:

> I took a call from RCMP about, you know, a few minutes later, where they said, "We just called and talked to your supervisor. Tell him he can't tell anybody what we just told him." And they made it very clear that they could not share that with us. And so I told the supervisor and said, "So what can't we know?" And they're like, "We can't tell you."[139]

Mr. Cox reflected on the impact of this direction on his workplace:

> So after the fact, our staff felt very, you know, who could we trust, you know, to share these things, because, you know, we're professionals. We want to keep our crew safe and we can't do that properly if we don't know what's happening out there.[140]

The EHS after-action report records that the information that the perpetrator was disguised as an RCMP officer was shared with EHS employees by computer-aided dispatch and email at 9:16 am on April 19. It is clear from the evidence that many EHS employees did not see this textual communication until after the critical incident response had ended. Management did not share this information by radio because EHS operates on unencrypted radio channels.

Bill Moore reflected on agency reluctance to share information with other emergency service providers:

> [W]hen I hear the terms "security", "privacy", they're roadblocks. If the conversation starts with those, they're thrown up as roadblocks, as opposed to starting with "We should be sharing information. Now, how are we going to deal with these other things?" … I get that conversation, but I think we need to change that conversation.[141]

Specifically on the topic of the challenges posed by some agencies having unencrypted radio communications, Chief Pike observed:

> The unfortunate part of that is that if you're using an encrypted channel, then all of a sudden, you know, you're not communicating with other agencies that don't have access. So you have to think about that. So that – sometimes that's where you have, you know, maybe your EMO person would be in the room with you so that they can kind of say, "Here's what's going on. Here's what you need to know."[142]

The paramedics we heard from emphasized the importance of trust and information sharing to successful deployment in a range of stressful or dangerous situations, including a mass casualty response. They had neither participated in interagency training for a critical incident response nor received agency training for mass casualty response, and they suggested that both of these things "would help a lot."[143] The EHS after-action report also states:

> Staff suggested that joint training would be greatly beneficial for establishing positive working relationships between the staff members of the various agencies. While upper management cooperation was acknowledged as a good strategy, it was felt that this does not always translate to cooperation on the ground (as evidenced by being blocked out of EOCs [Emergency Operations Centres]). Inter-agency participation in training exercises would improve trust, communication, and cooperation between front line staff and leaders.[144]

Positive examples of respectful working relationships also arose. In Volume 2, What Happened, we related the concern that Cpl. Duane Ivany showed for EHS members at the Plains Road scenes at approximately 10:00 am on April 19. When he learned that paramedics had not been told any information about the perpetrator, he advised them of the perpetrator's vehicle and disguise, and urged them to ask their dispatch to share this information.

Chief Alfred Grue of Bass River Fire Brigade advised the Commission that his brigade had conducted training with EHS but not with law enforcement. He also pointed to the cost involved in taking ambulances or RCMP members off the road to train for "something that might happen."[145] Chief Grue had a quite different perspective on his interactions with the RCMP than some others. On the night of April 18, he was warned by Valley Communications to stage rather than attending the fires in Portapique. His perspective may reflect the alertness of the Valley Communications dispatcher who picked up on the danger facing the MacDonalds, described earlier this chapter. The deputy chief of Bass River Fire Brigade, Steve

Brown, also dealt with the forensics team that worked daily in Portapique and found them "very professional."[146]

LESSON LEARNED

During a critical incident response, many agencies work together to address the threat and restore safety. It is essential that these agencies have a clear and shared understanding of their respective roles and responsibilities, that they have practised together, and that they can communicate effectively with one another.

Recommendation P.16

INTEROPERABILITY DURING CRITICAL INCIDENT RESPONSE

The Commission recommends that

(a) Clear protocols for unified command posts and agency roles and responsibilities should be established among all agencies involved in critical incident response.

(b) All emergency response agencies in Nova Scotia should be given access to encrypted radios while responding to a critical incident, even if these radios are loaned for the duration of that response. Emergency responders must be given the opportunity to train with these radios on a regular basis so that they are familiar with their use, when needed.

(c) Interagency scenario-based and tabletop exercises should be incorporated into existing agency training wherever possible. If this is not possible, agencies should regularly make time for dedicated interagency training.

Conclusion

The accurate capture and sharing of information – particularly information provided by community members – and timely analysis of that information are indispensable components of policing and specifically of an effective critical incident response. Sharing information in a timely manner with other responding agencies is essential to interoperability. RCMP training, policies, and procedures place too little emphasis on these skills. This institutional deficit reflects an institutional culture that undervalues the analytical and community-oriented aspects of policing, rather than a lack of resources. In Part D of this volume, we return to this theme, and explain that the RCMP's institutional devaluation of information provided by the community and fellow agencies and of information analysis is also reflected in its day-to-day activities, such as note taking and completing routine paperwork. Everyday practices and habits of accurate information recording and analysis are fundamental policing skills. Getting these practices and habits right on a day-to-day basis is a necessary precondition to effective information management in a complex critical incident response.

On April 18 and 19, 2020, the RCMP's information management practices proved inadequate to the demands of a large-scale critical incident response. In this chapter, we have explained the institutional processes that resulted in the incomplete capture and sharing of important information, starting from the earliest stages of the mass casualty. The institutional failure to adopt robust processes for recording, sharing, and using information that was provided by community members was compounded by the institutional failure to identify that there were witnesses and community members who had important information to share with the RCMP. The command group discounted reliable information about the perpetrator's replica RCMP cruiser that had been provided independently by eyewitnesses including Ms. Blair, the four children in the McCully home, and Kate and Andrew MacDonald.

CHAPTER 4

Public Safety During Critical Incidents

CHAPTER 4 Public Safety During Critical Incidents

In this chapter, we turn from the RCMP's internal processes for managing and sharing information to its approaches to warning community members and safeguarding public safety during the mass casualty. We address two aspects of this topic: the RCMP's use of Twitter and Facebook as the primary platforms for issuing public information during the mass casualty, including the timeliness and accuracy of information shared by social media; and the failure to issue a public warning using the Alert Ready system.

In the days, weeks, and months after the mass casualty, the RCMP was publicly criticized for failing to broadcast public warnings containing accurate and timely information during the unfolding incident. Family Participants, particularly families of those whose lives were taken on April 19, 2020, emphasized that, had the RCMP provided timely and accurate warnings of the danger facing the public with the best information then available to them, some or all of those who died on that day may not have been murdered. For example, the evidence shows that Kristen Beaton, Heather O'Brien, and Gina Goulet were actively monitoring the information that was being shared about the perpetrator and his actions.

We accept Participants' submissions that, if Ms. Beaton and Ms. O'Brien had received information that the perpetrator had left Portapique and was disguised as a police officer – complete with replica RCMP cruiser – in a more timely way, they could have chosen to stay home rather than leaving their homes to care for others. We also accept the submission from counsel for the Goulet family that, had Ms. Goulet received this information in a more timely way, she could have sought safety in the company of family or neighbours. The evidence also shows that Tom Bagley, Lillian Campbell, and Joey Webber left their homes on Sunday morning without knowing that a perpetrator was at large. They, too, may have made different choices, had they known they were placing themselves at risk by leaving their homes. The evidence abundantly demonstrates that lives can turn on ensuring accurate and timely public communications during a mass casualty.

In Volume 2, What Happened, we found that the RCMP's failure to publicly share accurate and timely information, including information about the perpetrator's disguise and replica RCMP cruiser, deprived community members of the opportunity to evaluate risks to their safety and to take measures to better protect themselves. We also found that essential workers, including Victorian Order of Nurses (VON) employees, were particularly at risk because of the nature of their work. The RCMP's failure to share accurate and timely information, including information about the perpetrator's disguise and replica RCMP cruiser, with these workers or their employers deprived these essential workers and their employers of the opportunity to evaluate risks to their safety and to take measures to better protect themselves. Finally, we concluded that the RCMP did not provide adequate or timely advice to community members about what precautions they should take to ensure their safety. In the absence of this information, community members adopted a range of strategies to stay safe, some of which may have put them at greater risk. In this chapter, we build on these findings by evaluating the institutional processes and decision-making that led to these failings.

The police responsibility to issue public warnings is clear. In 1990, Moldaver J (as he then was) held for the Divisional Court of the Ontario Superior Court of Justice in the case of *Jane Doe v Board of Commissioners of Police for the Municipality of Metropolitan Toronto* that

> [t]he law is clear that in certain circumstances, the police have a duty to warn citizens of foreseeable harm … The obvious purpose of the warning is to protect the citizens.[1]

In this case, a plaintiff whose name was protected from publication (hence, the pseudonym Jane Doe) argued that the Toronto Police Service had failed to protect the public because it did not issue public warnings about a serial rapist who had a known modus operandi, target victim group, and geographic range. The Divisional Court acknowledged that police have latitude in how best to achieve the ends of protecting the public: "[I]n some circumstances … the police might reasonably conclude that a warning ought not to be given." However, in these circumstances, "The duty to protect would still remain. It would simply have to be accomplished by other means."[2] The police responsibility to warn community members had been clearly established in Canadian law for at least 30 years by 2020, when the mass casualty happened. We emphasize that this responsibility has long been recognized because the RCMP and other Canadian police agencies have had many years to implement the policies and processes necessary to meet this responsibility.

Similarly, in the 2014 mass casualty in Moncton, New Brunswick, the RCMP recognized its responsibility to issue public warnings about the active threat presented by a perpetrator. In that instance, the RCMP recognized its responsibility to provide "accurate information" in the "quickest and most effective way."[3] The RCMP therefore used Twitter "in conjunction with news releases, news conferences and media availabilities as ways to communicate directly to the public."[4] The 2014 MacNeil Report regarding the RCMP's response to the Moncton mass casualty, which we will look at further in this chapter, specifically acknowledges the importance of public communications both for providing information to residents "so they could be safe" and for "establishing the messaging the community required in order to assist the frontline" police responders.[5] In short, the mass casualty in Nova Scotia was not the first time that the question of public warnings had arisen for Canadian police agencies, or for the RCMP.

The Attorney General of Canada has conceded that "[t]here is clearly much to be learned from the Mass Casualty with respect to public communications."[6] They acknowledge that "[t]here were missteps in communications to the public with respect to the initial incident as well as the replica RCMP car;"[7] and that the "evidence highlights the need for creating a better process for communicating with the public during a critical incident"[8] including the need for

> additional policy or training to reinforce the importance of the public safety aspect of strategic communications and thus the importance of releasing as much information as possible during a critical incident in the interests of public safety.[9]

We accept these submissions and welcome the RCMP's willingness to learn the lessons of April 2020. However, we emphasize that the RCMP was aware of the importance of public communications in critical incident response well before April 2020. The RCMP's failure to have adequate processes and training in place in H Division in April 2020 must be understood against this backdrop.

In the next section, we summarize the measures taken by the RCMP to alert residents in Portapique to the unfolding incident and the suggestions made by frontline RCMP members that steps should be taken to alert the public.

Steps Taken Early in the Critical Incident Response to Warn Portapique Residents

In Volume 2, What Happened, we described efforts taken by the RCMP to warn community members about the mass casualty and the internal RCMP discussions about providing public warnings. Starting at approximately 11:00 pm on April 18, 2020, the Operational Communications Centre (OCC) made efforts to contact Portapique residents directly in order to advise them to shelter in place in their homes. S/Sgt. Allan (Al) Carroll had instructed the OCC to contact as many residents as they could. We heard that this process was labour intensive, requiring call-takers to cross-reference several sources of information, and that the communications operators had "very little success" using the tools available to them. There were several reasons for this lack of success, including the fact that this strategy relied on land ownership records that were outdated and could not distinguish between permanent and seasonal residents and other owners of property.

The decision to expend OCC time and resources on this task at a busy time appears to have originated from a misunderstanding about the capacity of the 911 system on the part of the supervisors who were located at Bible Hill. Acting Insp. Stephen (Steve) Halliday testified that he had asked S/Sgt. Allan (Addie) MacCallum "to do his best to track who was in and who was out so we could try to understand who was still in those residences and who may be out and where they might be."[10] In his testimony, Acting Insp. Halliday confirmed that it was not until much later on that he became aware that the OCC did not have technology that would readily allow staff to call residents in a given location directly. S/Sgt. MacCallum described the process of engaging in direct outreach as a "tried-and-true method" that he had done himself "and had it done in countless situations to let people know to shelter in place."[11] S/Sgt. MacCallum's evidence on this point differed from the evidence given by OCC staff including that of call-taker Ms. Donna Lee Williston, who described the steps that she took to find some landline numbers and call residents. Ms. Williston, who had worked at the OCC for seven years at the time of the mass casualty and was call-taker supervisor that night, told us, "I'd never done that before."[12] We accept Ms. Williston's evidence that this method was neither routine nor simple. Rather, it proved to be a labour-intensive and largely fruitless exercise.

At about the same time, many of those who were in Portapique and nearby communities on the night of April 18, 2020, were calling 911 to report fires and/or gunshots. In some instances, these callers were advised to take precautions such as locking their doors, sheltering in a basement, or moving away from windows and doors. In other instances, callers were not given a warning of this kind. Some Portapique residents encountered first-responding RCMP members in person, either within the community or as they were seeking to evacuate. In his interview with the Commission, Cst. Stuart Beselt explained that, on occasion during the time that members of the Immediate Action Rapid Deployment spent in Portapique, they had knocked on doors in the hope of warning residents to evacuate or take shelter, but "there's a whole bunch of houses in there. Right. Like, you can't possibly go to all of them."[13]

We also explained in Volume 2, What Happened, that the question of whether information and instructions could be broadcast more generally to community members was raised at times by RCMP members who were involved in the critical incident response. At 11:16 pm on April 18, 2020, Acting Cpl. Beselt asked by radio, "Is there some kind of emergency broadcast that we can make that – make people go into their basement and not go outside?"[14] Cst. Beselt explained to the Commission that, at the time he raised this query, he knew "that they can put them [emergency broadcasts] out for Amber Alerts or whatever kind of thing. Right. So there is something that they can put out."[15] He later elaborated:

> I don't remember having ever put out a bulletin for, you know, in my 24 years of, you know, putting out some kind of alert. But this was something that I thought maybe we could put out an alert for … Like it was like … if there was a situation, this was it.[16]

Individual RCMP members and OCC employees turned their minds to issuing general public warnings, warning the Portapique community, or warning specific residents about the mass casualty. However, they were uncertain about the best means by which to issue these warnings. Some employees spent a great deal of time trying to figure out how best to alert community members, with little success. This uncertainty demonstrates a lack of standard policies, procedures, or training on issuing public warnings during a critical incident response.

Steps Taken to Warn the Public by Social Media and Media Updates

In Volume 2, What Happened, we provided a comprehensive account of the tweets sent and Facebook messages posted by the RCMP's Strategic Communications Unit over the course of the critical incident response. The first tweet, which was sent by Cpl. Lisa Croteau at 11:32 pm on April 18, 2020, read as shown here.

Twitter post made by RCMP NS, April 18, 2020, at 11:32 pm: COMM0013645

This tweet described the activity in Portapique as relating to a "firearms complaint" and advised the public to "avoid the area and stay in their homes with doors locked at this time."[17] Cpl. Croteau, who is a public information officer with RCMP H Division, explained that she was contacted by Sgt. Andrew (Andy) O'Brien, who "advised me that he wanted me to put out a Twitter message saying that the people needed to shelter in place in the Portapique area."[18] She said that Sgt. O'Brien did indicate that there were "some people … that were dead at the scene" but that "I didn't get into too much of the detail."[19] Cpl. Croteau selected this tweet from a "tweet bank" of pre-translated messages. She read the tweet out to Sgt. O'Brien "to make sure that was correct," and he approved it.

At 3:00 am on April 19, 2020, a CBC journalist telephoned Cpl. Croteau to ask if the situation in Portapique was ongoing, and whether there were any further updates. Cpl. Croteau replied that the advice to shelter in place remained current. By 8:00 am, CBC representatives were positioned at the Great Village fire hall. Cpl. Croteau had also travelled to Great Village, and in her Commission interview she recalled that "[m]y phone was ringing quite a bit because media from everywhere else, even abroad, was calling to find out information."[20]

The tweet that had been posted at 11:32 pm on April 18, 2020, was the only public information provided by the RCMP until 8:02 am on April 19, 2020, at which time the RCMP communicated the following information by Twitter:

> #RCMPNS remains on scene in #Portapique. This is an active shooter situation. Residents in the area, stay inside your homes & lock your doors. Call 911 if there is anyone on your property. You may not see the police but we are there with you. #Portapique.[21]

At 8:54 am on April 19, 2020, the RCMP provided the perpetrator's name, description, and photograph. In this tweet, a physical description of the perpetrator was shared and the public was asked to call 911 if they saw him. At 9:12 am, the RCMP made its first post to Facebook about the mass casualty. This Facebook post was a compilation of tweets sent before that time. Between 10:00 am and 10:21 am, the RCMP sent three further tweets with additional information about the perpetrator and his last known location.

In Chapter 3, we explained that, at approximately 7:25 am on April 19, 2020, the RCMP command group finally understood that the perpetrator may have been driving a fully marked replica RCMP cruiser. S/Sgt. MacCallum received a copy of a photograph of the vehicle by 7:30 am. At that time, however, the command group was still operating on the theory that the perpetrator remained in the Portapique area, and the photograph and information provided by Lisa Banfield and her family members did not immediately prompt a change in that strategy. We found in Volume 2, What Happened, that the command post did not take sufficient steps to reassess the strategic and tactical response, even after it began to consider the possibility that the perpetrator had escaped Portapique.

It was not until 10:17 am on April 19, 2020, that the RCMP posted information about the perpetrator's replica RCMP cruiser and disguise on social media. At that time, the RCMP sent the following tweet:

> #Colchester: [perpetrator's name] may be driving what appears to be an RCMP vehicle & may be wearing an RCMP uniform. There's 1 difference btwn his car and our RCMP vehicles: the car #. The suspect's car is 28B11, behind rear passenger window. If you see 28B11 call 911 immediately.[22]

A photograph of the replica RCMP cruiser was attached to this tweet. Two minutes later, the same information was posted on Facebook. After this time, updates were posted more frequently on Twitter and Facebook, with six tweets being sent between 10:39 am and 11:40 am. A press release was also issued at 10:36 am, directing media to follow the RCMP Nova Scotia Twitter account for further updates.

Neither Twitter nor Facebook automatically pushes updates to users' smartphones or other devices. Neither of these platforms is geo-targeted. Geo-targeting is a technology that ensures that messages go to all users in a given geographic area, and not to others. While a Twitter or Facebook user can express preferences about what notifications they receive, for the most part these social media platforms work by curating a feed, or list, of posts made by other users. The RCMP was unable to advise us how many followers the RCMP Nova Scotia Twitter and Facebook accounts had in April 2020, but as of February 2020 the numbers were as follows:

English language Twitter account: 75,612

French language Twitter account: 2,040

English language Facebook account: 82,249

French language Facebook account: 762

Each of these accounts could also be viewed by those who were not followers of the account.

The Commission was unable to determine how many times the RCMP Nova Scotia tweets and Facebook posts were viewed or shared during the active phase of the mass casualty. The RCMP produced a document that suggests the initial tweet, which was posted at 11:32 pm on April 18, 2020, was retweeted only once during the mass casualty by a media outlet – by a CTV journalist at 10:20 am on April 19, 2020. No information was available to the Commission about how many times the 8:54 am tweet containing the perpetrator's name, description, and photograph was retweeted. This tweet was later deleted by the RCMP "in consideration of the negative impact the images could have on those impacted by his acts."[23] This deletion occurred sometime before April 2021, when the analytical report was prepared. The 10:17 am tweet, in which the RCMP shared information about the perpetrator's disguise and the replica RCMP cruiser, including a photograph and the car number, was shared 16 times by journalists and news outlets in Nova Scotia, elsewhere in Canada, and internationally, during the critical incident response. It was also shared by three elected representatives: Darren Fisher, the member of Parliament for Dartmouth–Cole Harbour; Claudia Chender, who serves Dartmouth South in the Nova Scotia Legislature; and Elizabeth Smith-McCrossin, who serves Cumberland North in the Nova Scotia Legislature. Because of the way in which the RCMP provided these statistics, it is not possible to ascertain how frequently these

tweets and retweets were viewed during the period in which the perpetrator was an active threat.

Family members of those whose lives were taken were very critical of the RCMP's exclusive reliance on social media to convey information during the mass casualty. In Participant consultations and family meetings, we heard that many residents of rural Nova Scotia don't have social media, including many of those whose lives were taken on April 18 and 19, 2020. As an example, Ryan Farrington, whose mother and stepfather, Dawn and Frank Gulenchyn, were killed by the perpetrator, observed:

> My parents didn't have Twitter, they didn't have TV. They just had Internet, their cell phones and a radio. So if, you know, we utilize the public alert through cell phones and radios and stuff like that instead of just Twitter or Facebook, I think things might have turned out a little bit differently.[24]

Similarly, Harry Bond, whose parents, Joy and Peter Bond, were also killed, noted that "not everybody has Twitter feed … the internet down here is very sketchy."[25]

Strategic Communications During a Critical Incident Response

In April 2020, H Division policy about public communications was set out in instructions and standard operating procedures for risk managers regarding media relations duties. A public information officer was on duty from 8:00 am to 4:00 pm Monday to Thursday, and these instructions and procedures applied outside these hours. This document explained that "[t]he RCMP has a duty to inform the public on public safety issues." Risk managers were advised that the criminal operations officer should engage the Strategic Communications Unit for "a significant public safety or public interest issue (homicide etc.)." The murder of Greg and Jamie Blair and information subsequently received about the perpetrator's actions in Portapique plainly met this threshold very early in the critical incident response.

The RCMP's national *Tactical Operations Manual* states that, after the critical incident commander assumes command, she or he is responsible for "approving the

release of information to the media." The manual does not contemplate the sharing of information directly with the public, but also states that the critical incident commander is responsible for assessing evacuation efforts.

The criminal operations officer in April 2020 was C/Supt. Christopher (Chris) Leather. He was notified of a "double homicide and active shooter" incident by the district policing officer, Supt. Archie Thompson. C/Supt. Leather acknowledged this notification at 11:06 pm on April 18, 2020. C/Supt. Leather did not engage the Strategic Communications Unit, but S/Sgt. Brian Rehill reached out to the on-duty public information officer, Cpl. Croteau, at 11:20 pm. Cpl. Croteau reached the director of the Strategic Communications Unit, Ms. Lia Scanlan, at around 6:00 am on April 19. After that time, several members of the H Division Strategic Communications Unit were engaged in various aspects of public communications, including liaising with media; drafting and posting tweets, Facebook posts, and a media release; and monitoring social media. In her testimony, Ms. Scanlan explained that the strategy behind using social media was its capacity for rapid distribution and "amplification" of the message:

> It's to get information out as quickly – as quickly as we could. Because it's the only – social media is the only platform that allows amplification of your message, so instead of one-to-one, it's one-to-many.[26]

Ms. Scanlan elaborated that the capacity to retweet or share a post, including with personal commentary, is a key attribute of social media when the RCMP is seeking to reach community members directly.

In her testimony, Ms. Scanlan explained that the decision had been taken to move the RCMP's public communications primarily to Twitter and Facebook in approximately 2011. She explained that this approach had become the RCMP's preferred mode, rather than communicating by way of traditional media,

> ... because it was less about trying to make your information or pitching idea and making them relevant, and you now had an opportunity to communicate directly to your stakeholders on any matter.[27]

Although H Division continued to use news releases on occasion, Twitter became the primary platform by which the RCMP shared "breaking news." Ms. Scanlan explained that she saw social media as having significant advantages for this purpose, because it allowed users to share information directly and more widely

through their own networks. However, she was unable to answer further questions put by Participant counsel about analytics conducted by H Division regarding, for example, the reach of its social media accounts into rural communities in Colchester and Cumberland counties in Nova Scotia. Ms. Scanlan conceded that "there's no guarantee that a certain area or a certain demographic or a certain location is going to follow you."[28] She agreed with Participant counsel that traditional media, including radio, newspapers, and television, remain "very relevant," but observed that these outlets now receive "their information from us through Twitter."[29]

The RCMP's strategy emphasized the benefits of social media – particularly the capacity it provides the RCMP to communicate directly with its target audience without journalist intermediaries – and emphasized the goal of maximizing the total number of followers on each platform. However, the Strategic Communications Unit appears not to have accounted for the risks of an exclusive reliance on social media for public communications, nor to have generated strategies for reaching community members who do not use social media. Statistics Canada research, which focuses on Canadians aged 15 to 64, shows that regular use of social media platforms declines among those in older age groups. Most of those who use social media do so to keep up with family and friends, and only 44 percent of those aged 50 to 64 who use social media regularly do so to "follow current events."[30] Most Canadians who access news online go directly to specific news sites. The next most common means of finding news among Canadians is to conduct a Google search, a method which ranks "well ahead of platforms such as Facebook [and] Twitter."[31]

Ms. Scanlan explained in her testimony that the RCMP's strategy of relying on social media is predicated on the expectation that journalists and newsrooms will obtain newsworthy information by following the RCMP's social media accounts, predominantly Twitter. One of the drawbacks of using this strategy to disseminate current information is that its value for sharing time-sensitive information depends on constant active monitoring of the RCMP's Twitter account by journalists and newsrooms. In an era in which traditional newsrooms are shrinking, it is not realistic to expect that journalists will be on duty and monitoring Twitter at all hours of the day and night**. When time is of the essence, direct outreach to media by phone is a necessary supplement to the more passive strategy of posting updates on social media.**

We heard from several RCMP witnesses that they felt the value of using Twitter to communicate directly with the public during a critical incident response had been

demonstrated in Moncton, in 2014. In his report, on the Moncton mass casualty, in which three RCMP members were killed and two were severely injured, Ret'd. A/Commr. Alphonse MacNeil comments favourably on the Strategic Communications Team's use of Twitter in the critical incident response in 2014. In that instance, social media had been updated every 30 minutes, if not more frequently:

> Given the timing of the incident, approximately 19:20 on June 4, [2014] traditional media was not the immediate channel to get information to the public. The radio stations in Moncton had either switched to national programming or were automated (meaning the broadcast was pre-recorded). The daily newspaper would not be out until the following morning and their online service is subscriber based, meaning it was not freely accessible to the general public. The television evening news was over for the day and the next local TV broadcast was not for another three to four hours. This meant that social media was the quickest and most effective way to reach people in the shortest period of time. Given the seriousness of the incident, it was anticipated the information would be shared rapidly and to a wide audience. That was exactly what happened with followers to the RCMPNB and GRCNB feeds on Twitter and Facebook climbing at a staggering rate during the incident. Fortunately, "J" Division has been using social media for the past five years and had built an audience. The Strategic Communications team has experience using social media in a variety of incidents and knew the potential it had in reaching a wide audience.
>
> It is recognized that social media (Twitter and Facebook) is being utilized by RCMP Communications sections on a regular basis. In this case it was extremely valuable when used in conjunction with news releases, news conferences and media availabilities as ways to communicate directly to the public. It helped build credibility and maintained the organization's reputation as an accurate and authoritative source for information during this crisis.

The MacNeil Report documents a far more coordinated public communications strategy than that which occurred during the critical incident response in Nova Scotia in 2020. For example, media conferences were held at which the RCMP was joined by elected officials to provide information about the critical incident response and the work being done by other public authorities in response to the

ongoing incident. The MacNeil Report also states that over the course of the incident, the number of those who followed the RCMP New Brunswick social media accounts grew from 18,000 to more than 80,000. The report emphasizes that, in Moncton, Twitter and Facebook updates were used in conjunction with media briefings, press releases, and media availability.

The RCMP did not explain why it was unable to provide similar analytics to us about the RCMP Nova Scotia accounts and the mass casualty. However, we conclude on the basis of the evidence put before us that some Nova Scotia residents – including some whose lives were taken – were actively monitoring social media for updates on the morning of Sunday April 19, 2020, while others were unaware of the unfolding incident.

Ultimately, the MacNeil Report concludes:

> Having a continuous presence on social media during this crisis ensured *accurate information was disseminated in a timely manner* so as to counter any rumours or misinformation. It also acted as a calming tool, so that the heightened fear in the community did not escalate and affect public safety and security. Providing messages with a "call to action" that asked the public to engage allowed them to participate without interfering with police operations and did not leave them wondering what they could do.[32] [Emphasis added.]

Where Ret'd. A/Commr. MacNeil concludes that the RCMP conveyed accurate information to the public in a timely manner in Moncton in 2014, the same cannot be said of the RCMP's use of social media in Nova Scotia in 2020. The tweet sent at 11:32 pm on April 18, 2020, downplayed the incident in Portapique and conveyed no sense that there was an active shooter. It provided no information about the perpetrator, whose identity was known to the RCMP by this time.

MAIN FINDING

The tweet sent at 11:32 pm on April 18, 2020, was the only information shared publicly by the RCMP until 8:02 am on April 19, 2020. To the extent that the 11:32 pm tweet underplayed the seriousness of the threat to the public, the RCMP had ample opportunity to correct the public record. It took far too long to do so.

This delay may in part be attributed to the failure to promptly engage the Strategic Communications Unit, as was anticipated by standard operating procedures in place in April 2020. As we explain in more detail below, the delay also reflects uncertainty within the command post about who had responsibility for directing the release of information in order to ensure that the public received accurate and timely information.

After 8:00 am on April 19, 2020, the information shared by the RCMP was more accurate. Even so, the RCMP did not share *any* information about the identity of the perpetrator with the public until almost 9:00 am on the Sunday morning. We know that this information was important to those who then feared they may be targeted by the perpetrator. For example, Adam and Carole Fisher were able to take measures to prevent him from accessing their home in Wentworth because they were aware of the events in Portapique. Unfortunately, Sean McLeod and Alanna Jenkins may not have had the same opportunity to recognize the threat presented to them by the perpetrator when he arrived at their home on the morning of April 19, 2020, at approximately 6:35 am.

By about 8:00 am on Sunday morning, the Strategic Communications Unit was fully engaged in supporting the critical incident response. The RCMP received a photograph of the perpetrator's replica RCMP cruiser at around 7:30 am. Those RCMP witnesses who saw this photograph testified that they were shocked by how realistic the vehicle appeared and, at about this time, radio and OCC communications document a similar reaction on the part of RCMP members and employees. In our proceedings, Commission counsel and family Participants sought to elicit the reasons why the RCMP did not publicly share information about the replica RCMP cruiser until 10:17 am on April 19, 2020.

Members of the Strategic Communications Unit pointed out that they could not publicly share the photographs or information without approval from the critical incident commander or his delegate. Their evidence is consistent with RCMP policy, and we agree that operational command must authorize the release of information. We have two reasons for taking this view. First, the public release of information may have an operational impact – for example, on the behaviour of community members – and operational command must prepare for this possibility within the overall response. We emphasize, however, that this impact should not be assessed on the basis of myths or stereotypes about how community members will react to the dissemination of emergency information. Second, we accept that there may be investigative reasons to hold back some information, and operational command is

in the best position to assess this question. However, this too is a qualified principle, and the *Jane Doe* case shows that cautious evaluations of potential investigative significance should not prevail over the priorities of life and community safety. We have more to say on both these topics in the next section of this chapter.

We also heard evidence that confusion and miscommunication prevailed within both the command post and the Strategic Communications Unit about what release of information had been approved, and when.

S/Sgt. Jeffrey (Jeff) West testified that he had delegated responsibility for engaging the Strategic Communications Unit to Acting Insp. Halliday early in the critical incident response. He did not review the tweet that was sent at 11:32 pm on April 18, 2020, either at the time it was sent or afterward. He testified that, while "[t]here's always consideration, thought towards that, the public," he did not recall any specific conversation or thoughts about a public communication plan when he established the command post and took command. Ms. Scanlan called CIC West at approximately 7:00 am on April 19, 2020, and was directed to speak to Acting Insp. Halliday. This direction appears to be the first time CIC West expressly turned his attention to public communications.

Acting Insp. Halliday testified that he called Cpl. Croteau at around 5:00 am on April 19, 2020, to request that she attend the command post in the expectation that media would soon begin to arrive at or near the scene. At that time, he had had no conversation with Cpl. Croteau about tweets or public messaging. Cpl. Croteau in turn called her boss, Ms. Scanlan, who was then the director of the Strategic Communications Unit. At 7:15 am that morning, Ms. Scanlan called Acting Insp. Halliday. Acting Insp. Halliday testified that he asked Ms. Scanlan to liaise with S/Sgt. MacCallum. As had been true the previous evening when RM Rehill called Cpl. Croteau (rather than C/Supt. Leather doing so), there appears to have been little clarity between the Strategic Communications Unit and the command group about roles and responsibilities, even regarding liaison between the command post and the Strategic Communications Unit. We note in this regard that Ret'd. A/Commr. MacNeil recommended in 2014 that "standard operating procedures be developed to ensure communications personnel are part of the initial operational callout procedure for serious events."[33] Although some standard operating procedures existed in H Division, they were not followed on April 18 and 19, 2020, and there was no standard procedure for embedding a member of the Strategic Communications Unit in the command post or otherwise ensuring that the Strategic

Communications Unit is fully briefed and equipped to perform its responsibilities concerning public communications.

Acting Insp. Halliday and S/Sgt. West explained that between the time when the RCMP received information from Lisa Banfield and her family about the perpetrator's replica RCMP cruiser and 8:00 am on April 19, 2020, the efforts of the Emergency Response Team focused on ascertaining whether that vehicle was one of the two Ford Tauruses that had been found burnt out at the perpetrator's properties in Portapique, and on seeking the whereabouts of a Ford F-150 that was also associated with the perpetrator. Commission investigators later identified the remains of the Ford F-150 in photographs of the perpetrator's burnt-out warehouse, consistent with Ms. Banfield's statements on the morning of April 19, 2020. Acting Insp. Halliday testified that he regarded the content of social media posts as being the preserve of the Strategic Communications Unit, and he did not expect to be asked to approve social media posts.

For his part, S/Sgt. MacCallum testified that when he first spoke to Ms. Scanlan, at about 8:10 am on April 19, he asked her to draft a public communication about the replica RCMP cruiser. However, he was awaiting confirmation from the Emergency Response Team that neither of the two burnt-out Ford Tauruses in Portapique was the replica RCMP cruiser before approving public disclosure of this information. Other evidence suggests that the Emergency Response Team had confirmed at about 7:55 am that neither of the cars located in Portapique had a light bar or silent patrolman – information that CIC West and Acting Insp. Halliday considered ruled out the possibility that these were the vehicles of which the RCMP now had a photograph. S/Sgt. MacCallum had a further conversation with Ms. Scanlan at about 8:45 am in which he confirmed that the replica RCMP cruiser was unaccounted for. He testified that he understood at that point that this information would now be publicly shared.

S/Sgt. MacCallum testified that he did not understand his role in public communications to be a continuing one: "[A]t that point, I felt that my task was completely done."[34] For this reason, he did not appreciate when he left the command post to become directly engaged in the search for the perpetrator that a request for approval would come to him. In fact, Cpl. Jennifer Clarke, a member of the Strategic Communications Unit who was then helping Ms. Scanlan to prepare public communications, emailed a draft tweet to S/Sgt. MacCallum at 9:40 am on April 19 for his approval. (This email was in accordance with Ms. Scanlan's instructions to Cpl. Clarke.)[35] Within five minutes, Cpl. Clarke realized that S/Sgt. MacCallum

was unavailable and redirected this email to Acting Insp. Halliday. Acting Insp. Halliday testified that he was not checking email and did not see this request, but that he received a call from Cpl. Clarke at approximately 9:49 am and provided verbal approval of the proposed text.

Meanwhile, at 8:44 am on April 19, Acting Cpl. Heidi Stevenson had raised a query by police radio about whether the information about the perpetrator's replica RCMP cruiser should be publicly shared. RCMP dispatcher Ms. Lisa Stewart sent a message to dispatch supervisor Mr. Bryan Green: "[Enfield members] requesting a media release re 28b11 being an imposter." There is no record of Acting Cpl. Stevenson receiving a response to her query. However, the question was passed along to RM Briers, who in turn contacted S/Sgt. Carroll at the command post at 9:00 am. S/Sgt. Briers testified that the decision to release information of this kind "should go through the Critical Incident Commander."[36] RM Briers and S/Sgt. Carroll had a brief phone conversation "about doing a media release about this vehicle potentially out on the go."[37] S/Sgt. Carroll confirmed that this plan was under consideration. In this call, RM Briers asked S/Sgt. Carroll whether there was anyone else in the command post he could approach with requests of this kind, but S/Sgt. Carroll confirmed that such requests should be directed to him.

At 9:08 am, S/Sgt. Carroll sent RM Briers an email saying that "[t]hought was given to give release about vehicle, but decision was made not to."[38] RM Briers confirmed receipt at 9:15 am and commented, "Kind of figured they may not want to release."[39] In fact, as we explained above, by 8:45 am a decision had been taken within the command post to publicly release the information about the replica RCMP cruiser. In his testimony, S/Sgt. Carroll was unable to explain how this misunderstanding arose, noting that he "reached out to Staff Halliday via phone" after speaking with RM Briers, and "that was the end result of the discussion, that it's not going to be released at this point in time."[40] However, S/Sgt. Halliday testified that he "had no recollection of anyone saying that they would not be releasing the information" and that "at 9:08 am, it had already been contemplated and prepared to have been sent out."[41]

We have set out this evidence here because it further demonstrates the lack of clarity around roles, responsibilities, and decision-making within the command group during the critical incident response. This lack of clarity adversely affected the response and, in this instance, resulted in incorrect information being provided to the Operational Communications Centre about the status of public communications. It was important for the OCC to have accurate information about the RCMP's

public communications. Publicly releasing the information about the replica RCMP cruiser increased the volume of 911 calls, as members of the public reported potential sightings of the vehicle. Indeed, the "strain … on the communication system" was one of the risks the command group considered when deciding whether to release this information.[42]

Ms. Scanlan and Cpl. Clarke also testified about the course of decision-making and approval about sharing the photograph of the perpetrator's vehicle and associated information about his disguise. Ms. Scanlan testified that her recollection of the conversation with S/Sgt. MacCallum at around 8:00 am on April 19 is that it focused solely on releasing information about the perpetrator's identity. She did not receive operational direction to prepare to release the photograph of the replica RCMP cruiser and associated information about the perpetrator's disguise until approximately 8:40 am, when it was given by the district policing officer, Supt. Archie Thompson. At around 9:00 am, Ms. Scanlan tasked Cpl. Clarke with preparing a draft tweet. Cpl. Clarke agreed that she had received direction to prepare a draft tweet at approximately 9:00 am. In her testimony, she explained why it then took her about 40 minutes to prepare this draft:

> There was a lot going on in the background, including speaking with Corporal Croteau, who was on the ground in Portapique … She didn't know what was happening. She's trying to deal with the constant phone calls, and I was concerned that she needed to keep her head up and know what was going on, just because she's sitting in a marked police car wearing a uniform and may have to respond operationally as opposed to, to the phone and to media relations, so there was that aspect of things. There was simply trying to grasp the idea that there was someone who was basically hiding in plain sight using, you know, the uniform and a police car looked just like us, and trying to understand that, and then trying to get the information. There were two or three phone calls that I made to Staff Halliday and Staff MacCallum trying to get information, and as I was making those phone calls, people were being killed.[43]

The Operational Communications Centre received the first call from Hunter Road in Wentworth at 9:19 am on April 19, 2020. Thereafter, matters moved extremely rapidly. Mary-Ann Jay reported that her neighbour Lillian Campbell was dead after "a big bang, like a gun shot" and that an RCMP vehicle had been sighted on Highway 4 outside Wentworth, at 9:35 am. At 9:38 am, smoke and more gunshots were

reported by April Dares at Hunter Road in Wentworth. Cpl. Rodney Peterson saw the perpetrator on Highway 4 at 9:47 am, and at 9:48 am Adam and Carole Fisher made separate phone calls to 911 to report that the perpetrator was at their residence in Glenholme. As we explained in more detail in Chapter 2 of this volume, as this information was dispatched by radio, the command group appreciated that the perpetrator was an active mobile threat.

RCMP command and those in the Strategic Communications Unit were properly concerned about the risk to RCMP members, given the perpetrator's disguise. Cpl. Croteau had no mobile work station or carbine in her vehicle at Great Village and, in any event, given her media liaison role, would have been unable to follow live radio or text updates. Given that role, a member of the command team should have assumed responsibility for her safety and that of the media who were also stationed at Great Village. At the very least, once it became apparent that the perpetrator may have left Portapique in a fully marked police vehicle, Cpl. Croteau should have been directed by those who had asked her to attend the command post to take cover inside the Great Village fire hall or to leave the command post immediately in order to protect her from being placed in the vulnerable position that Cpl. Clarke described.

In her interview, Cpl. Croteau explained to the Commission that it was Cpl. Clarke who directed her to leave Great Village. Cpl. Croteau reflected that, at that time,

> my phone was constantly ringing because at that point we had released a police car and the person's name. So, I had calls from every … the UK, from the States, everywhere. So, I kept having to pull over and I didn't think that was being safe either, so, at one point I just … once I got to Truro, I just put my phone down and I just kept driving. And at that point, we also knew that he was around Onslow. So, I was keeping an eye for him, but also making sure nobody … like if someone else, other officers came around me to make sure they knew my position so that I didn't want to have a situation happen where they thought I was the bad guy … And my goal was to … I have to get to Headquarters because I need to be able to speak to media.[44]

Consistent with its overall lack of contingency plans for the possibility that the perpetrator had left Portapique, the command team had not made a plan for the safety of those members who were stationed at the Great Village fire hall and performing responsibilities that distracted them from keeping a lookout for a mobile active

threat. One significant consequence of this oversight is that, at a time when it was absolutely imperative to share information with the public for their safety, the Strategic Communications Unit's attention was drawn by the concern to ensure the safety of its own members. This situation not only was dangerous for Cpl. Croteau but it also impaired the effectiveness of the RCMP's public communications work. This situation – like the overall lack of preparedness for incorporating public communications into a complex critical incident response – is symptomatic of an institutional culture that undervalues community relationships and public communications.

Notwithstanding these extraordinary circumstances, Cpl. Clarke had drafted a tweet about the perpetrator's vehicle and disguise by 9:40 am. At this time, she emailed S/Sgt. MacCallum for approval. Cpl. Clarke quickly realized that S/Sgt. MacCallum had departed from the command post to search for the perpetrator, without advising the Strategic Communications Unit of his change in role. She redirected her email to Acting Insp. Halliday, whom she then called. Acting Insp. Halliday approved the tweet by phone at 9:49 am.

Cpl. Clarke then immediately sought final approval from Ms. Scanlan to send the tweet. At that time, Ms. Scanlan was not monitoring her email because she was briefing her second in charge, who had recently come on duty, and responding to requests from another member of the Strategic Communications Unit. Cpl. Clarke tried to call Ms. Scanlan a couple of times and re-sent the email twice in the ensuing minutes. In testimony before us, Cpl. Clarke described the period between 9:49 am and 10:17 am as "the longest 27 minutes of my life."[45] Ms. Scanlan confirmed that Cpl. Clarke could not have reached her by telephone because she was on two phone calls – one on each of her phones – at that time.

In our proceedings, Ms. Scanlan reflected on the misunderstanding that led Cpl. Clarke to believe that she required further approval from Ms. Scanlan before sending this tweet:

> [W]hen I said [S/Sgt.] Addie [MacCallum] can approve the tweet, I meant that I didn't need to see it, but I clearly wasn't explicitly clear in that.[46]

While the delay in drafting and obtaining approval for this tweet is explained by the confusion and sense of immediate danger that prevailed during this period, it represents a serious institutional failure of process and procedure. Here, as elsewhere, the failure to make contingency plans for the possibility that the perpetrator had escaped Portapique affected the quality of the critical incident response. In this

instance, that failure was compounded by the failure to bring the Strategic Communications Unit into the critical incident response from the outset, thus depriving that unit of the opportunity to establish a strategic or coordinated approach to public communications throughout the incident.

Ms. Scanlan suggested that standard operating procedures should be developed with input from the Strategic Communications Unit and critical incident command or operational leadership, to ensure that a misunderstanding of this kind never arises again. We agree that here, as elsewhere, standard operating procedures and a clear prior allocation of roles and responsibilities would go a considerable distance toward avoiding the kind of confusion that prevailed at this time. However, we note that a similar recommendation was made in the MacNeil Report and that it has been marked as "implemented" by 2015.[47]

The affidavit provided by Insp. Pharanae Croisetiere explains that Ret'd. A/Commr. MacNeil's recommendation that "standard operating procedures be developed to ensure communications personnel are part of the initial operational callout procedure for serious events" was marked as implemented after an email was sent to all OCC commanders, advising them that "if it was not already standard practice, they should review their divisional SOPs [standard operating procedures] for critical incident call outs and liaise with their divisional strategic communications teams to include them."[48] Here, as was also true with initial critical incident command training for front-line supervisors, we conclude that the RCMP's standard for marking a recommendation "implemented" is inadequate. In April 2020, H Division had a generally worded standard operating procedure that required the criminal operations officer to call out the Strategic Communications Unit. However, this procedure was silent on crucial issues including the role played by the Strategic Communications Unit; the process and ultimate responsibility for authorizing public communications; and the methods of public communications. Furthermore, even the minimal process set out in the standard operating procedures was not followed on April 18 and 19, 2020. The evidence abundantly demonstrates the degree to which confusion arose in the roles and responsibilities of the command group, the Operational Communications Centre, and the Strategic Communications Unit as a result of this lack of process.

At this juncture, we wish to record that Ms. Scanlan particularly expressed her sorrow at the delay in sharing information about the perpetrator's vehicle and disguise: "It's just … just know that if I could go back and have those minutes disappear, I would do anything. I just need people to know that, and we'll do better."[49]

Cpl. Clarke similarly reflected, "I wish I could have gotten [the information about the perpetrator's disguise and replica RCMP cruiser] out earlier."[50] At the same time, as she acknowledged, "it wouldn't have been productive to anyone to start going rogue."[51]

Almost three hours transpired between the time when the RCMP first received confirmation that the perpetrator possessed an extremely realistic replica RCMP cruiser and the time when it shared that information with the public. More than two hours passed between the time when the RCMP confirmed that this vehicle had not been destroyed in Portapique and the time when the information was provided to the public by Twitter. In each instance, the time was far too long. The RCMP's failure to provide timely and accurate information to the public about the unfolding mass casualty began with the understatement contained within the tweet sent at 11:32 pm on April 18, 2020, but it is most palpable with respect to this delay in sharing information about the perpetrator's disguise and replica RCMP cruiser. This failure is attributable to a combination of factors, most of which were within the RCMP's control. The most significant of these factors were the failure to fully engage the Strategic Communications Unit at the outset of the critical incident response; and the confusion that prevailed within the command post about who was responsible for liaising with strategic communications and directing the release of operational information. These matters lay within the purview of the critical incident command group and the criminal operations officer, and they were not attributable to the Strategic Communications Unit. Indeed, the fact that the Strategic Communications Unit was not engaged in accordance with standard operating procedures at the outset of the critical incident response meant that this unit had to scramble from a standing start on the Sunday morning of April 19, 2020. This circumstance likely contributed to the confusion about decision-making responsibilities, communications content, and approval processes.

LESSON LEARNED

Effective public communication during critical incidents requires clear policies, planning, and training. When police do not communicate effectively, community members may be unaware of an active threat to their safety and/or unsure about how to stay safe.

Recommendation P.17

PUBLIC COMMUNICATION DURING CRITICAL INCIDENTS

The Commission recommends that

(a) The RCMP should amend its policies, procedures, and training to reflect the approach recommended in the 2014 MacNeil Report about the RCMP's response to the Moncton Mass Casualty; that is, that the RCMP should activate public communications staff as part of the critical incident package.

IMPLEMENTATION POINTS

- The responsibility to prioritize and engage public communications staff must be clearly allocated.
- A public communications officer should be embedded within the command post.
- Effective implementation of this recommendation requires far more than an email to RCMP employees.

(b) The RCMP should train critical incident commanders and front-line supervisors in their responsibilities to provide timely and accurate public communications about a critical incident. This responsibility should be stated within RCMP policies and procedures.

(c) The RCMP should fully integrate public communications into its approach to critical incident response, including training and tabletop scenarios, and communications officers should train and practise alongside other members of the command group.

IMPLEMENTATION POINTS

- Procedures for approving the timing and content of public communications should be set out in standard operating procedures and regularly practised.
- Strategic communications units should extend their template communications database to address a wider range of content and

potential scenarios. This database should be continually updated on the basis of new incidents and insights from training and practice.

(d) Consistent with their legal duty to warn the public, police agencies should disseminate public information using methods that ensure that public communications reach those who are most affected by an incident in a timely manner. When choosing communications strategies, police agencies should attend to matters of equity and substantive equality, including demographic differences in the use of social media platforms, as well as the accessibility of reliable internet and cell service.

IMPLEMENTATION POINTS

- Effective public communications may require different strategies in different circumstances, or for different sectors of the community.
- When a public communication is issued about a critical incident or similar event, the strategic communications unit should conduct a post-incident review of the timeliness, accuracy, reach, and effectiveness of the public communication.

Alert Ready

As we describe in Part B of this volume, after the mass casualty a great deal of public attention was focused on the RCMP's failure to initiate a broadcast warning using the Canadian emergency alerting system, which is known by the trade name Alert Ready. In this section, we consider the history of institutional decision-making that gave rise to a situation, in April 2020, in which the command group was unaware of the potential to use Alert Ready to broadcast a public warning about a mass casualty. We then discuss the evidence we received about the risks and benefits of issuing a public alert during a mass casualty.

The History of RCMP Decision-Making About Alert Ready

In Volume 2, What Happened, we noted the history of RCMP decision-making about Alert Ready, in particular the decision taken in early 2012 not to explore the opportunities offered by Alert Ready. Mr. Mark Furey, who was the Nova Scotia attorney general and minister of justice at the time of the mass casualty, was the program manager for the RCMP H Division Emergency Management Section from November 2011 until September 2012. At that time, he held the rank of staff sergeant in the RCMP. He explained to the Commission that in late 2011 and early 2012, the Nova Scotia Emergency Management Office approached the Emergency Management Section to explain that Alert Ready was a "tool that would / could afford the law enforcement community the opportunity to use public broadcasting (television / radio at that time) to disseminate and /or communicate information to the public at large, if and when the opportunity, and/or need, presented itself."[52]

At that time, S/Sgt. Furey saw potential utility in this tool and prepared a draft briefing note for the H Division criminal operations officer recommending that the RCMP explore this potential. Such briefing notes had to be approved by the support services officer and "Criminal Operations [CrOps] reviewer" before being forwarded to the criminal operations officer, who was then C/Supt. Brian Brennan. Mr. Furey explained to the Commission that the support services officer and CrOps reviewer "were not supportive of the concept – they expressed strong opposition."[53] They advised him that they would not approve the draft briefing note without amendment. Mr. Furey told the Commission that the eventual briefing note "reflects what my superiors advised they would approve from my office."[54] This note, which was produced to the Commission, was the product of "[n]umerous and difficult discussions"[55] which "were not productive in advancing a more robust document and interest in" Alert Ready.[56]

The Commission also obtained a copy of a second briefing note, in which S/Sgt. Furey identified that, if public alerting were implemented, risk managers would require training in order to author such alerts. This note observes, under the heading "Recommendations / Strategic Advice," that "[m]anaged properly, the availability and application of a PAS [public alerting system] in Nova Scotia could / would be considered an asset to front line police service providers, in response to emergency situations (i.e., forest fires, floods, meteorological events, etc.)."[57] It appears that this briefing note was not approved by the support services officer

and CrOps reviewer, and for this reason it may never have been submitted to the criminal operations officer.

Mr. Furey told the Commission that his "frustrations with the SSO [support services officer] and CrOps Reviewer were key factors in my decision to retire early" from the RCMP.[58]

The executive director of the Nova Scotia Emergency Management Office (EMO), Paul Mason, advised the Commission that the office started issuing test alerts using Alert Ready in 2015. **In 2016, the Nova Scotia Emergency Management Office offered "trusted user status" to the three largest police agencies in Nova Scotia: RCMP, Halifax Regional Police, and Cape Breton Regional Police, but at that time this offer was declined by all three agencies. "Trusted user status" permits a police agency to issue alerts directly, alleviating the need to work via the Emergency Management Office.** Between 2014 and 2019, the EMO made a number of presentations to police agencies in Nova Scotia about the possible applications of public alerting in policing. On at least one occasion, in 2016, a presentation identified the possibility of using Alert Ready in an active shooter situation.

In April 2018, Alert Ready began transmitting directly to cellular phones. The EMO issued 16 test alerts between December 2015 and April 2020. The first live alert message was sent in Nova Scotia on April 10, 2020, regarding public health measures associated with the COVID-19 pandemic.

In Volume 2, What Happened, we explain that a representative of the EMO contacted Mr. Glenn Mason, the civilian manager of the RCMP Emergency Management Section, toward the end of the mass casualty. This phone call was placed by Mr. Michael Bennett at 11:14 am on April 19, 2020, to advise that the EMO was prepared and ready to use Alert Ready to send a broadcast alert upon request by the RCMP. S/Sgt. Steven (Steve) Ettinger, who was then acting as a second risk manager in the RCMP Operational Communications Centre, approved the proposal to use Alert Ready. No Alert Ready message was broadcast, because the perpetrator was killed a few minutes after this approval was given.

In our proceedings, several RCMP witnesses emphasized that at the time of the mass casualty, they were not aware that Alert Ready could be used for an active shooter situation or ongoing police incident. S/Sgt. West, the critical incident commander on April 19, testified that "it was not a tool in our toolbox that we were – we knew of to use in a critical incident setting."[59] C/Supt. Darren Campbell echoed this explanation:

> [T]he reason why that wasn't considered at that time, certainly my belief is the Critical Incident Commander is the person responsible for understanding all the information and making the decisions with respect to public alerting. And at that point in time, it was described to me by others is that wasn't a tool that we were aware of that we had in our tool box. So that, obviously, I believe, was a contributing factor as to why the Alert Ready system was not used, because it wasn't in the front of the minds of the individuals who would have been responsible for determining whether an alert was most appropriate.[60]

When asked to explain why Alert Ready was not a tool in the toolbox, C/Supt. Campbell responded:

> Well, I think the simple answer to that question is, is that, you know, everything boils down to training and communications, and if it's not part of training … if that tool was not understood, if that tool was not exercised or made available or practised, then they would have no awareness of it, they would have no practical experience with it. And that is a challenge because they all did say – and I'll use a direct quote that they said to me, "That wasn't a tool in our toolbox."[61]

However, as we explained at the outset of this chapter, Cst. Beselt expressed a different perspective. Recalling as he responded to the mass casualty that broadcast messages could be issued for missing people, he knew there was "something that I thought maybe we could put out an alert for"; and "if there was a situation, this was it."[62] Accordingly, at 11:16 pm on April 18, he specifically asked by police radio whether "some kind of emergency broadcast" could be issued.[63]

We find that on April 18 and 19, 2020, key decision-makers, including critical incident commanders and risk managers, did not consider the possibility of sending a public broadcast message using Alert Ready, and that they had not been trained in the use of this tool. Counsel for the RCMP submitted that "while members knew there was a system that was used for weather warnings and Amber Alerts, it had not been considered for policing situations."[64] We disagree. **The evidence we have summarized here shows that various levels of management at H Division RCMP had been advised of the potential utility of Alert Ready for policing applications since 2011, including active shooter incidents since 2016, and that senior RCMP management in H Division had not embraced that advice. The persistent lack of attention to the opportunity afforded by Alert Ready reflects the RCMP's broader**

lack of attention to preparing for critical incidents, and particularly to the role of public communications during such incidents.

MAIN FINDING

On April 18 and 19, 2020, key RCMP personnel, including the command group and risk managers, did not consider the option for an emergency broadcast to be sent via the Alert Ready system until the Nova Scotia Emergency Management Office contacted the RCMP directly. This failure to consider issuing an emergency broadcast reflects a systemic failure on the part of RCMP H Division, over several years, to recognize the utility of Alert Ready for its emergency public communications. This systemic failure persisted despite individual efforts to draw the attention of H Division's leaders to the opportunities afforded by Alert Ready.

The Risks and Benefits of Issuing a Public Warning

C/Supt. Leather testified that an alert was not sent using Alert Ready "because no one knew how to use" the Alert Ready system, and that there was "no operational knowledge of it within the RCMP."[65] However, C/Supt. Leather maintained that issuing a public alert would not necessarily have been the right decision, had RCMP members been aware of that option:

> [D]eploying that technology under the circumstances that we had with Portapique with the perpetrator driving a police vehicle dressed as a police officer, there are significant public and officer safety risks associated to that that would have had to have been analyzed and would have been analyzed by the CICs in a scenario such as that before they would agree or not to issue an alert.
>
> They would have to satisfy themselves that the need to inform the public using an alert was not recklessly going to put members of the public or police officers responding in harm's way by the issuance of the alert. And looking at this from the outside, it seems quite clear that that could, in fact, be a significant risk associated to a deployment alert under those circumstances.[66]

C/Supt. Leather did not elaborate on these potential harms. As we explain in Part B of this volume, after the mass casualty, RCMP H Division retained KPMG, a consulting firm, to facilitate a process in which the RCMP identified and evaluated the risks of using Alert Ready. The risks identified by the RCMP in KPMG's May 2022 report include that:

- a perpetrator may change their behaviour in response to an alert;
- the alert may generate a change in public behaviour that increases risks to public and police safety;
- an alert may contain inaccurate or unconfirmed information, or prove to be a false alarm;
- an alert may not be received by some members of the public, "negating the value of the alert";
- others may opportunistically take advantage of the decreased ability of the police to respond by engaging in criminal behaviour; and
- calls to 911 and police lines will exceed capacity.[67]

We address the RCMP's concerns about capacity to respond to an increased volume of calls in response to an alert in Part B of this volume. For now, it is sufficient to note that **the evidence we received suggests that 911 calls have not exceeded overall system capacity when alerts have been issued. We also note that the Nova Scotia public safety answering point system (i.e., the 911 call-taking system) was able to manage the increased volume of calls it received on Sunday, April 19, 2020, when the RCMP's tweets and Facebook posts about the critical incident, the perpetrator's identity, and the perpetrator's disguise were being publicly circulated.**

A number of the other risks listed in the KPMG Report either reflect myths about how members of the public will respond to information about an active threat, or can be minimized with appropriate preparation and public education.

In Chapter 1 of this volume, we described the evidence given by expert witness Michael Hallowes, who told us that "warnings are for the informed."[68] Mr. Hallowes, a former detective chief superintendent of the Metropolitan Police Service in London, England, has also been involved in the design and implementation of public warning systems in several countries. **Effective community education can address the risk that community members might call 911 without having timely information to share and can also ensure that community members are prepared to assist those who may not receive an alert or may need more time to respond.** Carefully

pre-scripted messages can also assist with these risks; for example, by providing alternative means of contacting police with non-urgent information or a non-emergency information line for a community member to call if they are seeking advice about what to do in response to the alert.

The operation of myths about how community members will respond to public warnings is a topic that has been addressed in several forums, both in our proceedings and elsewhere. In Chapter 1 of this Volume, we referred to the published research of Dr. Bjørn Ivar Kruke, of the University of Stavanger in Norway, on the public role in responding to crisis. Dr. Kruke describes the belief that community members will panic or become helpless, thereby increasing the challenge of an emergency response for first responders, as myths that prevent police and other emergency responders from properly valuing and planning for the community contribution to crisis response. Dr. Kruke also describes the belief that significant numbers of community members will opportunistically commit crimes such as looting during a crisis as a myth. In fact, he reports, crime tends to decrease during such incidents.

Mr. Hallowes also addressed a number of misconceptions about public alerting. He drew on his own experience to explain that it is important to issue a public warning based on the best information then available, and to provide updates as necessary:

> I'm always very concerned by something called the "paralysis of accuracy," whereby you wait and wait for the perfect situational awareness and you miss telling the public what they need to know right now, "And I'm sorry, if I got it wrong, I'll tell you I got it wrong, and I'll correct it." But waiting for this perfection of the information, it doesn't happen.
>
> If we take the '07 terrorist attacks in London, I was right there in the control room, it took us more than 60 minutes to work out that we were under attack from four coordinated terrorist attacks. That's the reality. In that hour, we said nothing to the public. We should have been able to say something that said, "This is what we are dealing with," where it is, our understanding, "We'll update you." Saying nothing in this day and age allows non-official channels, like social media, to then dominate, to the fill the gap with inaccuracies, unchecked information.[69]

Mr. Hallowes's example refers to a terrorist incident in London, England, on July 7, 2007, in which the perpetrators detonated four explosive devices on public transit

(three in the London underground, and one on a bus). 52 people were killed in these bombings.

We particularly wish to emphasize Mr. Hallowes's observation that public communications will occur whether or not emergency authorities choose to provide guidance. **Many of the RCMP's identified risks of sending an alert implicitly assume that in the absence of an alert, people will remain unaware of a critical incident or that they will not change their behaviour in response to other information. As Mr. Hallowes notes, in the absence of authoritative information from police or other emergency service agencies, misinformation can flourish.**

The evidence we heard about the community's response on April 18 and 19, 2020, shows that community members actively looked for authoritative information about what was happening during the mass casualty, including by calling 911 to seek information. It also shows that in the absence of clear information, community members did their best to keep themselves and one another safe by sharing whatever information they could find. **In other words, the police choice between sending a public communication and not is not a choice between advising the public that an incident is unfolding, and pursuing a critical incident response without any public knowledge of the event in progress. Rather, in circumstances such as a prolonged mass casualty incident, it is a decision between ensuring that the public receives clear information about how an incident in progress may affect them, and what steps they can take to be safe; and expecting community members to figure these things out for themselves.**

It is also important to note that the RCMP did not refrain from public communication during the mass casualty. To the contrary, the Strategic Communications Unit posted information on Twitter and Facebook precisely because these platforms allow community members to share posts with others in their networks. C/Supt. Leather explained to the Commission that he considered it to be an obvious decision to share information including a photograph of the perpetrator's replica RCMP cruiser on social media: "There was never any debate on that call or subsequently about once we are in possession of the pictures of distributing them" publicly via Twitter and Facebook.[70] We find it difficult to square the suggestion that there may have been unacceptable risks associated with sending an alert containing this information with this acknowledgment. **The difference between tweeting this information and sending it via an alert is the overall proportion of community members who receive the information. Public access to urgent community safety information should not be rationed, and it certainly should not turn on whether a**

given community member uses social media. Although it unfortunately remains true that some community members will not receive an alert issued via Alert Ready, in a circumstance such as the mass casualty of April 2020, any technology that significantly increases the reach of a public warning is worth employing. In Volume 4, Community, we discuss obstacles to universal access to Alert Ready and ways to address equity concerns associated with this technology.

Finally, we note that the RCMP listed the risk that a perpetrator may change their behaviour and the risk that the public may respond in unhelpful ways to an alert among the risks to be considered before sending an alert. These risks were considered in *Jane Doe v Metropolitan Toronto Commissioners of Police*. In that case, the Toronto Police Service had refrained from issuing a public warning about a serial rapist in part because they were concerned that women who may be victimized would panic or "become hysterical" in response to such a warning and that this response would prompt the perpetrator to change his behaviour.[71] Justice MacFarland found that the Toronto Police Service had breached its duty to warn Jane Doe of the threat presented to her and so deprived her of her opportunity to take steps to protect herself. Justice MacFarland held that the manner in which the Toronto Police Service approached their decision about whether to issue a warning also breached Ms. Doe's rights under sections 7 and 15 of the *Charter*.[72] Section 7 of the *Charter* relevantly guarantees every person the right to security of the person, and section 15 relevantly guarantees every one the right to the equal protection and benefit of the law without discrimination.

In *Jane Doe,* MacFarland J emphasized that a decision whether to issue a public warning must not be made on the basis of discriminatory beliefs or stereotypes about how potential victims will react to such a warning. In the particular case, she held that "the conduct of this investigation and the failure to warn in particular, was motivated and informed by the adherence to rape myths as well as sexist stereotypical reasoning about rape, about women and about women who are raped."[73] The problematic reasoning that underpinned the police decision not to issue a warning was described succinctly by Moldaver J in the Ontario Divisional Court (as he then was) as follows:

> [T]he defendants had a legal duty to warn her of impending danger. They chose, or at least adopted a policy not to warn her because of a stereotypical and therefore discriminatory belief that as a woman, she and others like her would become hysterical and "scare off" the attacker. As a result, she was turned into "bait", without her knowledge or consent.[74]

The same reasoning underpinned Ms. Doe's claim that her section 7 right had been violated:

> The plaintiff claims that she was deprived of her right to security of the person. The defendants chose, or at least adopted a policy which favoured the apprehension of the criminal over her protection as a targeted rape victim. By using Ms. Doe as "bait", without her knowledge or consent, the police knowingly placed her security interest at risk. This stemmed from the same stereotypical and therefore discriminatory belief already referred to.[75]

It is clear from the *Jane Doe* case that a decision not to issue a public warning must be made on the basis of a reasoned consideration of the risks and benefits entailed. Myths and stereotypes about how community members, or a sector of community members, might respond to such a warning must not enter into the calculation.[76] (We define the terms myths and stereotypes in Volume 3, Violence.)

In our process, one RCMP witness suggested that issuing a public alert about the perpetrator's disguise might have resulted in community members taking matters into their own hands and potentially firing on legitimate police officers. In particular, this belief was tied to the rural context of this mass casualty and to the stereotype that in rural communities, people engage in direct self-help rather than relying on police. A similar concern about the risks of public alerting is expressed, albeit without the specific reference to rural communities, in the KPMG Report:

> Due to the fact the public may not fully understand the risk and/or their required response, the public will have varied reactions potentially resulting in public, police and first responder safety being impacted.
>
> During past police-related emergencies, RCMP have observed changes in behaviour that could increase risks to public, police and first responder safety. Issuance of alerts may increase the likelihood of triggering changes in behaviour that could have adverse impacts.
>
> ...
>
> Implications
>
> Alerts may cause mass panic, citizens taking up arms, going to the incident site to view, sharing officer locations / activities, purposely

> providing false information, etc., impacting safety and potentially impeding RCMP operations and investigations.[77]

This risk was given an aggregate score of 16, which means that the RCMP rates it as "expected" to arise and as having a high impact on an important aspect of RCMP operations or on public or police safety.

Throughout our Report, we have emphasized the crucial role played by community members in a critical incident response. We have discussed the corrosive impact of police treating community members as adversaries, rather than allies, in securing community safety. We have documented abundant evidence of community members providing reliable information to police and placing themselves directly in harm's way to assist others, including police.

We have found no evidence of mass panic or of community members taking up arms against police officers or deliberately sabotaging a police response. To the contrary, when the information about the perpetrator's disguise was publicly shared, community members called 911 to report sightings of police vehicles in an obvious effort to help the critical incident response. To the extent that some of these sightings were of legitimate police vehicles, this was readily verified using the tools available to 911 call-takers.

An exercise in assessing the risk of issuing public warnings that operates from the premise that community members are untrustworthy or more prone to sabotage a police response than to aid it places the security interests of community members in danger on the basis of dangerous and divisive myths. The reasoning that a particular community, such as a rural community, is more inclined to respond rashly to public warnings and that this is a reason not to issue such a warning relies on stereotypes rather than on the reasoned assessment of risks and benefits that Canadian law requires.

MAIN FINDING

The widespread beliefs that community members will panic and that they cannot be trusted to respond appropriately to information about threats to their safety are myths. These myths persist despite abundant evidence to the contrary. These myths have no legitimate place in police decision-making about whether to issue a public warning about an active threat to community safety.

Recommendation P.18

ISSUING PUBLIC WARNINGS

The Commission recommends that

(a) When an active threat to the public exists, police agencies should share the best available information about the nature of the threat and how to remain safe with the public as soon as possible. Police agencies should be prepared to correct or update information as necessary.

(b) Police and emergency services agencies should tailor the means by which public warnings are issued to the location, scale, and duration of a threat. Police and emergency services agencies should ensure that public warnings reach as many community members within an at-risk population as possible.

Recommendation P.19

TRAINING PERSONNEL TO ISSUE PUBLIC WARNINGS

The Commission recommends that

The training police agencies give to critical incident commanders and risk managers should emphasize the duty to issue public warnings and equip these personnel with tools to identify when a public warning is necessary and to decide how best to issue that warning.

Recommendation P.20

ADDRESSING MYTHS AND STEREOTYPES ABOUT COMMUNITY RESPONSES TO PUBLIC WARNINGS

The Commission recommends that

The RCMP and the Canadian Police College should incorporate material that identifies and counters the operation of myths and stereotypes about

community responses to critical incidents into immediate action rapid deployment training, initial critical incident response training, and Canadian Police College training for critical incident commanders.

Recommendation P.21

NON-URGENT PUBLIC INFORMATION LINE

The Commission recommends that

The Nova Scotia Emergency Management Office should work with Nova Scotia police agencies to establish a phone line and website that can be used by community members to report non-urgent information during a critical incident and to obtain further information about how to respond to a public warning. Information about this facility should become a standard inclusion in public warnings about critical incidents.

Recommendation P.22

PUBLIC EDUCATION ABOUT PUBLIC WARNINGS

The Commission recommends that

The Nova Scotia Emergency Management Office and Nova Scotia police agencies should engage in a public education campaign, including in schools, to increase public awareness about public warnings and public understanding of how to respond to these warnings.

Part B:
The Continuing Crisis

CHAPTER 5

Post-Event Learning

CHAPTER 5 Post-Event Learning

In this chapter, **we evaluate the steps taken by the RCMP after the mass casualty to examine its response and learn from the incident.** We focus on two issues. The first is whether RCMP members who responded to the mass casualty participated in effective operational debriefing after the event. The second is action taken by RCMP executive leadership to understand what went well and to identify key weaknesses or gaps in the RCMP's critical incident response in order to make informed decisions about how to better prepare for future complex critical incident responses. Police and other emergency agencies may use a variety of strategies to evaluate and learn from a critical incident response. This chapter focuses on operational debriefing, after-action reports, and after-action reviews. Operational debriefings are distinct from psychological debriefings. Operational debriefings focus on the operational aspects of an institutional response. Psychological debriefings focus on the health and well-being of employees who may require psychological support after performing demanding work.

The Commission's investigations revealed that the RCMP did very little to examine their response to the mass casualty. For the most part, general duty members who joined the critical incident response and their supervisors did not participate in operational debriefing. Although members of two specialized teams – the Emergency Response Team and the Emergency Medical Response Team – did participate in operational debriefings, there is uncertainty about whether they properly submitted their after-action reports to those in charge of the H Division Critical Incident Program, namely Insp. Donald (Don) Moser and Supt. Darren Campbell. The critical incident commanders did not participate in operational debriefing or prepare an after-action review. Further, despite considerable internal discussion about the need for the RCMP to conduct an after-action review of its response to the mass casualty, the RCMP did not do so.

Effective Post-Event Learning: A Pillar of Effective Critical Incident Response

We explained in Chapter 1 of this volume that effective post-event learning is a key principle of effective critical incident response. Police organizations are primary responders to mass casualties and other emergencies. **Activities that facilitate learning and strengthen future preparedness include operational debriefing, after-action reviews, and dissemination of lessons learned.**

Key Strategies for Institutional Learning

Police agencies use a variety of formal and informal strategies to learn from a critical incident response. Key strategies include three mechanisms that are discussed in this chapter.

An *operational debrief* is a facilitated conversation with those involved in a critical incident response or subgroups of involved personnel. The purpose of this debrief is to allow responders to reflect on their response, to ask one another questions, and to identify what went well and areas for future improvement. A debrief may identify a need to clarify policies and procedures, a gap in training and preparedness, or other areas for future improvement.

An *after-action report* is a report produced by those involved in the critical incident response or their direct supervisors. It captures lessons learned and recommendations for future preparedness and response. After the mass casualty, the RCMP Emergency Response Team and Emergency Medical Response Team produced draft after-action reports, but did not formally submit them.

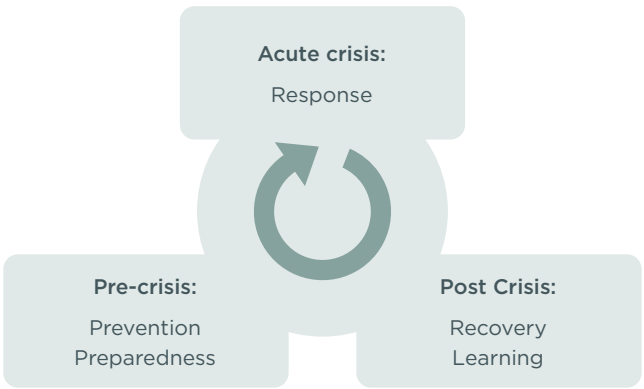
An *after-action review* is a more structured process of analysis of a critical incident response, often conducted by an independent expert. The RCMP's independent officer reviews are an example of after-action reviews conducted internally. An Ontario Provincial Police review of the RCMP security posture at the time of the Parliament Hill shootings on October 22, 2014, is an example of an external after-action review.

Dr. Bjørn Ivar Kruke, whose expertise and experience are described in the Chapter 1 of this volume, has observed that "[t]he willingness and commitment to learn from a traumatic mass casualty event can be decisive for building future capacity in response organizations."[1] A demonstrated willingness to learn after a crisis also plays a role in "rebuilding or even enhancing the relationship of trust between the population and the authorities."[2] Many institutions, including police agencies, now conduct debriefs and after-action evaluations as a standard practice following a critical incident or complex institution-wide operation, and especially when public trust has been shaken.[3] The public reasonably expects that the institutions working on their behalf will be committed to effectiveness and accountability, and after-action evaluations are one mechanism to meet those commitments.

Models of *crisis phases* are instructive for the Commission's analysis in this section. As we explained in Chapter 1 of this volume, these models generally contain three basic phases: pre-crisis, acute crisis, and post-crisis. **In the pre-crisis phase, the focus is on prevention and preparedness. The acute crisis phase is when a crisis requires immediate response to reduce the consequences of the event. In the post-crisis phase, the priorities are recovery and learning, with the aim of "put[ting] communities and agencies [in] a more robust position than that prior to the crisis."**

Importantly, as illustrated in the figure below, crisis phases should be understood as cyclical. In other words, the post-crisis phase for one event is also the pre-crisis phase for the next event. In this sense, crisis preparedness may be understood as "a continuous but evolving process whereby learning from each crisis leads to more robust capacity to deal with subsequent crises and disasters."[4]

The Cycle of Crisis Phases



Source | Bjørn Ivar Kruke, "Police and First-Responder Decision-Making During Mass Casualty Events."

No General Operational Debriefing After the Mass Casualty

The vast majority of RCMP employees who were involved in the critical incident response of April 18 and 19, 2020, never participated in an operational debriefing. These employees include general duty members, critical incident commanders, general duty supervisors who formed part of the command group, risk managers, and Operational Communications Centre (OCC) employees. In this section, we explain the purpose and value of operational debriefing before relating the evidence we heard from RCMP members.

There are several reasons for conducting an operational debriefing after a critical incident, including facilitating individual and team learning and building trust within teams. In our roundtable discussions, Supt. Wallace Gossen of the York Regional Police in Ontario offered insight on this point:

> And, you know, the – we call that, the immediate debrief afterwards, the hot wash … And it's literally before everybody packs up and goes home. Again, these are, you know, depending on the event … [A]nytime we had a call, you are going to debrief it at least to identify what did we do good and what can we improve on … In the event that this turns around and happens 24 hours later, what can we fix, right, so that we're in a better position the next time it comes around? And it almost always boils down to equipment and communication for the most part. And it's also very beneficial for individuals to fill in the knowledge gap. I mean, I may be looking at you thinking, "Why did you do that?" And then in the debrief, I find out, I'm like, "Oh, that makes sense." And that's, I think, psychologically very important, especially when you're trying to build trust in the team.[5]

In this passage, Supt. Gossen describes an operational debriefing performed immediately after an incident. This immediate debrief may not be possible following a prolonged and severely traumatic critical incident such as the April 2020 mass casualty. During our roundtable discussions, roundtable members explained that in some cases, responders to a critical incident will need to engage in a psychological debriefing before operational debriefing can take place. For example, retired Rector Kimmo Himberg of the Finnish National Police University College explained that

> [T]his psychological support to officers needs to be clearly separated from an evaluational phase of – or an evaluation of the operation itself. There is often no hurry with that. So, when necessary, the [psychological] debriefing needs to be done first, before all those involved are ready to enter a phase where actions are being assessed, and decisions that were made are being evaluated.[6]

The mass casualty is an example of an incident in which it was appropriate to conduct psychological debriefing and provide necessary psychological supports to members before conducting operational debriefing. After the mass casualty, the RCMP did conduct psychological debriefing sessions with most responding members and employees. However, the organization never moved into the phase of operational debriefing.

Operational debriefing is a process by which the experiences of those on the ground, especially the challenges they faced during the critical incident response, are collected and clearly communicated to management, who have the power to make change. The deputy chief of the Cape Breton Regional Police, Stephen MacKinnon, explained the importance of hearing from individuals involved in all aspects of the critical incident response when assessing an incident and planning for the next one:

> So it's mandatory where we're at. Everybody has a voice, and that's from the – every containment traffic officer who experienced being left there for six hours and somebody forgot about them, and it was a hot day, and so – because your next experience with that individual, no matter what part they are of that plan, has a direct effect on the successful outcome of the following, the continuing. **So we treat everybody as – sometimes we put tactics up here, and – or containment here, but it's all part of the success of that plan, so everybody has a voice in that**.[7]

The value of operational debriefing will vary based on how it is conducted. **The Commission heard evidence that if not conducted properly, operational debriefing can be useless or even harmful to those involved. For this reason, an operational debrief or review cannot be treated simply as a "checklist" item in the post-crisis phase.** As Supt. Gossen explained, facilitating and participating effectively in operational debriefing are skills. Like all skills, practice is necessary to develop them:

> [M]y experience has been **people have to practise admitting they made a mistake** or being honest and you need to generate trust and be non-judgmental, which unfortunately with a lot of these situations, you can't help but be. And that's why I think it's very important who does the debrief; right? .... You know, if it's a situation where there's going to be criticism and we know there's going to be, it needs to be done by somebody who has been there, done it, and is going to be sympathetic to somebody who is in that situation. **And again, debriefing is a very complex thing. And, the worst debriefs you can do, in my experience, are you throw everybody in a room together and say, "Okay. Let's go through what happened." It really needs to get broken down into trusted groups, where those individuals can go and talk amongst themselves** ... I've found, psychologically, it can be very difficult for people in a large group that they don't know, being, shall we say, not challenged, but sometimes it feels like you're being interrogated, especially if you don't know that person, and trust that person, or at least have an understanding of where they're coming from. **Your debriefs can almost be to the point where you may as well not even do them, because you're not going to get the honest feedback that you need.**
>
> So again I think, everybody here has hit on it. Debriefing is a skill ... It's a skill for the person that's conducting it. It's also a skill for the individual that's being debriefed. And the only way that you get those skills is through experience, and it doesn't have to be – I think, that practice of doing the debrief at the end, just even for minor things, let's just have a quick conversation about what happened, goes a long way towards debriefs in the future going better for you when you do hit a major event.[8]

The RCMP has no general policy requiring an operational debriefing after a mass casualty incident, or in other circumstances. Deputy Chief MacKinnon's and Supt. Gossen's descriptions of facilitating operational debriefings with those involved in a critical incident response as a standard institutional practice is not shared by the RCMP. However, S/Sgt. Kevin Surette, a trained critical incident commander, described an informal process adopted by the critical incident commander group in H Division at its quarterly meetings:

> [W]e would hash out every call we'd had in that previous quarter, so we all had a good understanding, make sure we're on the same page with everything that had transpired, lessons learned, so continue with development from that perspective … It didn't always happen that way, but we try our best to make that happen.
>
> And I think it's worthy of note that, as a critical incident commander, we have no full-time critical incident commanders in the division, so it was always something that we were doing above and beyond our substantive role.[9]

This form of operational debrief is more limited than the type described by Deputy Chief MacKinnon and Supt. Gossen, as it is confined to critical incident commanders, and it appears to be largely focused on individual and team development rather than being oriented toward identifying institutional lessons learned or needs, such as a need for particular training or equipment. We agree with S/Sgt. Surette that it is noteworthy that this practice was not built into the substantive responsibilities of trained critical incident commanders, but essentially conducted as a voluntary exercise when other responsibilities permitted. **An institution that is dedicated to learning lessons from past responses and implementing those lessons will value the time and human resources required for these tasks.** Requiring critical incident commanders to do this work off the side of their desk sends an implicit institutional message that operational debriefing is something that happens when and if personnel can find time for it, rather than being core to institutional effectiveness.

Supt. Gossen described operational debriefings, when well conducted, as a space in which those involved in a critical incident response can come to a shared understanding of why certain decisions were taken and why events played out as they did. The lack of operational debriefing in this instance was difficult for some members. In his interview with the Commission, S/Sgt. Surette described his experience in the days and weeks after the mass casualty in terms that illustrate the importance of providing this opportunity to involved members:

> I was missing a lot of information when I arrived, and I don't mean that to be critical of anybody. [CIC] Jeff [West] had his hands full the whole time and there was lots of information that [we] learned, kind of through discussion after the fact that I had no idea about. And I will say this, too, and again, I'm not trying to be critical of the organization or anything. But when I left there that day and came home … Had no information from the force whatsoever for the next year.

S/Sgt. Surette described learning details of the critical incident response and mass casualty from the media, rather than from colleagues. It is clear from his interview that he and other members were discussing aspects of their experience and seeking to support one another, and that psychological debriefings were offered to members. As we explain below, some efforts were made to collect insights from responding members. In short, it is not that these debriefings were prohibited. It simply appears that no one got around to conducting them. S/Sgt. Surette explained that the lack of an opportunity to hear the perspectives of others who played a different role in the critical incident response has been important to him:

> [E]ven though I was an Incident Commander involved in this whole thing, it's a very small piece of that whole pie. There's a lot that happened and a lot of members, a lot of police officers out there that day who did things and said things that I had no idea about. And you know, it's just, it's mind-boggling. Everybody involved has a story, right.[10]

The RCMP critical incident commanders met on April 19, 2020, after the perpetrator was killed, but S/Sgt. Jeffrey (Jeff) West explained that this meeting was not an operational debriefing:

> PARTICIPANT COUNSEL: … But let me ask you this, so there was a debriefing, I believe, Staff West, you said after the perpetrator was apprehended, for lack of a better word, back in Bible Hill?
>
> S/SGT. JEFF WEST: Yes, at the Bible Hill Detachment.
>
> PARTICIPANT COUNSEL: Right. And would there have been best practices – I realize it's right on the heels of this whole incident, but a discussion of things that could have been done differently throughout the two days? Would you –
>
> S/SGT. JEFF WEST: Not at that time.
>
> PARTICIPANT COUNSEL: Okay.
>
> S/SGT. JEFF WEST: That more was to wrap up the Critical Incident Response and to hand over to the Major Crime because now it's gone from being a critical incident to a Major Crime investigation.[11]

S/Sgt. West identified that the purpose of this meeting was to share information with the Major Crime Unit after the command post had been shut down. From that point forward, the Major Crime Unit would assume responsibility for continuing investigation.

Ultimately, the critical incident commanders did not hold an operational debriefing or produce any after-action report about the mass casualty. A/Commr. Dennis Daley told the Commission he was surprised to learn that the RCMP does not have a policy requiring critical incident commanders to complete after-action reports. He advised the Commission that the RCMP has "taken steps" to update its *Tactical Operations Manual*, to require the critical incident commander of an incident to submit an after-action report in every instance.[12] The RCMP did not provide the Commission with any draft policy or other documents indicating the content of this potential policy amendment.

S/Sgt. Daniel (Dan) MacGillivray, who was the critical incident commander from approximately 10:20 am on April 19, 2020, until the perpetrator was killed, explained that conducting operational debriefings with general duty members and preparing after-action reports is the responsibility of the detachment commander, with oversight from the district advisory non-commissioned officer and the district policing officer:

> It doesn't feel like an operation is complete if you don't do it … my last four years of the organization, I was a District Advisory NCO, of which if there was a major event happened anywhere in Southwest Nova, my role was to make sure it did happen. So, and most often I didn't have to tell a Commander that he needs to have one or she needed to have one, it was, "Okay, here's when it's happening." So, that's a very important aspect of our culture and our organization now, is to do after action. So, we would expect them … I know our District Policing Officer would insist on after-action reports for major events or significant events.[13]

However, the approach to operational debriefing and after-action reports that S/Sgt. McGillivray described was by no means universal within the RCMP. At best, it appears to vary by district and leader. Very few operational debriefings were conducted after the mass casualty. General duty members and their supervisors and Operational Communications Centre personnel did not participate in any operational debriefing despite playing key roles in the critical incident response. Supervisors who were centrally involved in the critical incident response including

S/Sgt. Brian Rehill, S/Sgt. Allan (Al) Carroll, S/Sgt. Stephen (Steve) Halliday, S/Sgt. Allan (Addie) MacCallum, and Sgt. Andrew (Andy) O'Brien, did not participate in an operational debriefing session.

In a meeting held by District Policing Officer Supt. Archie Thompson with Amherst detachment members on 30 April 2020, members identified that they wanted some means by which they could share information with senior management "on what took place."[14] This request does not appear to have prompted an operational debriefing, but C/Supt. Christopher (Chris) Leather subsequently attended a meeting with these detachment members. C/Supt. Leather explained that he assigned Supt. Constantine (Costa) Dimopoulos, a member of the Issues Management Team, the task of

> learning from the members what we could do better in terms of our operational response … [W]hat could we learn and do in the interim to address concerns that the members would raise about the 18th and the 19th [of April 2020] and our response, constraint concerns, operational concerns.[15]

This process was pursued informally and not pursuant to any policy. In June 2020, Supt. Dimopoulos emailed some RCMP members to solicit feedback about their operational concerns related to the mass casualty response. However, Supt. Dimopoulos received just one written response, and only one member opted to meet with him. C/Supt. Leather told the Commission that little was learned from this process although it did provide an opportunity for "cathartic release" to the members who participated.[16] However, Supt. Dimopoulos characterized what he gathered from meetings with general duty members at Amherst and Bible Hill detachments somewhat differently:

> [I]t was clear to me that there was a lot of, there was a lot of angst in those two detachments. They were … they were upset, generally upset that there was a lot of media bashing and that a lot of criticism levelled against the RCMP or the suggestion that there were some leadership issues that failed them, specifically, that the force was being silent on a lot of the information that was coming out in the media. So it affected their morale, and it also affected the operational tempo of the two detachments.[17]

These quite specific concerns led Supt. Dimopoulos to expect that he would be "buried in responses" to his email request for input.[18] He was therefore surprised when he did not receive more uptake. The one email that Supt. Dimopoulos did receive was produced to us, with the identity of the sender and certain other information redacted. It contained a number of operational insights from the perspective of a member who attended Portapique on the night of the mass casualty. They include:

- the need for a better tool for members, the Operational Communications Centre, and command post to automatically track the location of other members, including the need for the mobile work station mapping function to be less "cumbersome";
- the benefit of issuing dark-coloured uniform shirts because they create less of a target when searching for an active shooter;
- the time taken to get the command post up and running. The member suggests that having a permanent command post in divisional headquarters "would enable an experienced incident commander to take control of the situation much quicker" and alleviate the burden of setting up a command post from scratch;
- that containment was problematic: "To be blunt, containment of the scene was not done," the member states, noting that members were not provided with direction as to containment; and
- the lack of opportunities to train with municipal police services "so members could learn to work together efficiently and become familiar with each other's areas of operations."[19]

The member also raises concerns about a conversation overheard between "two S/Sgts." in the command post in which these senior members discussed reprimanding members who had self-deployed to the critical incident response. The concern is respectfully articulated and the member states that they are "very alive to the fact that I was not (and am not) aware of all details and facts surrounding this incident."[20]

Each of these points, including the member's expressed concern about the manner in which the two staff sergeants spoke about the actions of general duty members self-deploying, is constructive and important to an overall institutional evaluation of the critical incident response. This email provides a glimpse into insights that the RCMP could have gained from a more systematic approach to operational

debriefing. Supt. Dimopoulos advised us that he shared the information provided by this member with C/Supt. Leather but did not prepare an after-action report or written document recording these insights.

Supt. Dimopoulos advised us that he did not pursue his efforts to gather operational insights because, in the course of this assignment, an RCMP member disclosed allegations of criminal conduct by members of another police service to him.[21] At that point, Supt. Dimopoulos's focus turned to recording those allegations and reporting them to C/Supt. Leather, and he did not continue with his intended debriefing process.

General duty members and their supervisors were the initial responders and decision-makers during the early stage of the critical incident response in Portapique on April 18, 2020. It was during those first minutes and hours that the RCMP received critical information from eyewitnesses and was required to make important decisions, including how to contain the area and what resources and tactics to deploy in the hot zone. Throughout the ensuing critical incident response, general duty members played a central role that included, among other responsibilities, staffing a containment perimeter, providing scene security, and searching for the perpetrator. **The absence of proper operational debriefing among general duty members and their supervisors is a missed opportunity for the RCMP to learn from the experiences of these members and supervisors. It also deprived these members and supervisors of an opportunity to reflect on the operational aspects of the critical incident response. These missed opportunities represent a failure of institutional leadership on the part of the RCMP.**

After-Action Reports

The national RCMP *Tactical Operations Manual* requires the team leader of the Emergency Response Team to conduct a debriefing with its team members and other support units, in conjunction with the incident commander. The policy directs the team leader to "ensure discussions cover all aspects of the operation from activation through briefing, deployment, communications, tactics used, and the outcome."[22] Team leaders must prepare and submit a debriefing report to the incident commander, who in turn must complete that report "and forward to national and

divisional ERT coordinators, on all ERT deployments."[23] Reports about equipment deficiencies or failures follow a slightly different process. An operational debriefing was conducted after the mass casualty with the Emergency Response Team and the Emergency Medical Response Team. No notes were taken during that debriefing session.

The RCMP disclosed two after-action reports to the Commission: a report prepared by the RCMP H Division Emergency Response Team ("ERT After Action Report"), and an RCMP H Division Emergency Medical Response Team after-action report ("EMRT After Action Report").

The "ERT After Action Report" provides a chronology of Emergency Response Team member actions; details their movements and tactical decision-making; and identifies "best practices," "operational gaps," and "investigational gaps," grouping some crime scenes together.[24] Best practices included, for example, the decision to assign an Emergency Response Team member (Cst. Benjamin (Ben) MacLeod) to travel with Police Dog Service member Cst. Craig Hubley to provide overwatch. As the report identifies, this decision proved important when these members encountered the perpetrator at the Enfield Big Stop. Operational gaps identified in the "ERT After Action Report" include the challenges presented for situational awareness by the unavailability of ATAK (android tactical assault kit) and RCMP air support (both discussed in Chapter 3 of this volume) and by a shortage of ERT members in H Division. Investigational gaps include delays in informational exchange (also discussed in Chapter 3). In short, the Emergency Response Team identified many of the challenges that we found to have adversely affected the critical incident response.

The "EMRT After Action Report" provides a chronology of actions taken by Emergency Medical Response Team members Cpl. Duane Ivany and Cst. Jeffrey (Jeff) Mahar, who responded directly to several scenes during the critical incident response. It also discusses the role of two other EMRT members who responded but did not play an active part. The report identifies gaps and lessons learned from the critical incident response, including the impact of a shortage of trained EMRT members in H Division, the lack of a vehicle capable of transporting injured victims, challenges in interoperability with Emergency Health Services personnel and mitigation strategies for these challenges, and a lack of clarity in the policy guidance given to EMRT members about when to initiate resuscitation efforts during an ongoing mobile active threat.[25]

There were difficulties related to the completion, submission and review of both of these reports.[26] Counsel for the RCMP initially advised the Commission that these reports had been submitted to both the H-Strong support services officer and the Operational Readiness and Response Branch of Contract and Indigenous Policing. Commr. Brenda Lucki testified that she had been told soon before testifying that "[t]hey're completed reports with recommendations and they're in the midst of implementing recommendations."[27]

Cpl. Timothy (Tim) Mills, who was the ERT team leader in April 2020, testified that the "ERT After Action Report" was never finalized. He explained that the report was still in draft form when he retired amidst conflict with H Division management:

> I was going to review the document, submit it, but then, you know, how busy we were with all the calls and basically by the time I've had enough with upper management and walked out the door in November, it was still a draft copy.[28]

Other H Division leaders also understood that the "ERT After Action Report" had never been finalized or submitted. In final submissions, counsel for the RCMP conceded:

> It was not clear whether either report had been submitted through the H Division Support Services office or to the National Critical Incident program. There was no indication that the reports had been reviewed or supported by division or program management.[29]

If normal procedures had been followed, the ERT team leader would have submitted the "ERT After Action Report" to H Division Support Services for review and approval before being submitted to national headquarters. However, in this case, the ERT team leader did not submit the report to H Division Support Services for approval. Instead, he sent the report directly to national headquarters. There was uncertainty about what if anything was done with the report once it reached national headquarters. The Commission asked the RCMP for any records pertaining to the report's submission to the National Critical Incident Program, but the RCMP did not provide any email or other document showing when or to whom the report was sent.

Supt. Phil Lue, who at the relevant time was the director of the RCMP national Critical Incident Program, offered an explanation that may account for why the

RCMP was unable to provide any record of the "ERT After Action Report" being submitted to national headquarters or unable to confirm when and to whom it was submitted. It was Supt. Lue's impression that the Emergency Response Team was hesitant to submit the report for approval by H Division leadership because the report "would put management in a bad light and then there might be repercussions."[30] He speculated that Cpl. Mills simply sent the draft report directly to his "good friend" Insp. Jamie McGowan, who was then the officer in charge of the national ERT program in Ottawa and was formerly a member of the H Division ERT.[31] Supt. Lue acknowledged the complexity of the interpersonal dynamics then in play in H Division, observing that "there's always two sides to stories."[32] In Chapter 10, we return to the challenges that arose in the relationship between the ERT and H Division leadership after the mass casualty.

In any event, it is unclear where the "ERT After Action Report" went once it was received by whoever received it within national headquarters. Supt. Lue did not recall seeing the document until it was provided to him by his counsel before attending an interview with the Commission on August 24, 2022. Similarly, regarding the "EMRT After Action Report," Supt. Lue told the Commission that he could not recall whether he reviewed the report. He explained that the report would have been submitted to officers in the national EMRT program, who would have considered whether to "push it up the chain to my level, the Director level, and then the Chief Superintendent, Director General level, to get some type of change made."[33]

Despite initial uncertainty about the status of these reports, toward the end of the Commission's proceedings the RCMP did compile a summary and record of actions taken in response to them. The August 17, 2022, summary prepared by C/Supt. Michael O'Malley sets out changes made since the mass casualty that pertain to issues addressed in the Emergency Response Team and Emergency Medical Response Team reports, as well as identifying matters that have not been addressed.

These reports suggest the value of a systematic institutional process for operational debriefing and preparation of after-action reports. However, they do not reflect the experiences of responders outside the Emergency Response Team and Emergency Medical Response Team, including general duty members, general duty supervisors, and Operational Communications Centre personnel. Accordingly, even if they had been completed and properly submitted and analyzed by leadership, the "ERT After Action Report" and "EMRT After Action Report" alone could not give RCMP leadership a thorough understanding of the gaps in H Division's

preparedness for a major incident such as the mass casualty. If the RCMP's operational debriefing process is limited to specialized teams such as the ERT, their needs and perspectives will naturally be prioritized over those of members who are responsible for other crucial contributions to the management of the critical incident, particularly in the initial stages of the response. **An overall view of the response is needed to allow RCMP leadership to effectively assess and prioritize which areas require change or resource investment most urgently.**

The After-Action Review That Never Was

As set out at the beginning of this chapter, the Commission's examination of the RCMP's post-event learning processes involved two main areas of inquiry. The first area, addressed in the previous two sections, is the absence of proper operational debriefing for RCMP members and Operational Communications Centre personnel who responded to the mass casualty. The second issue, addressed in this section, is the question of whether RCMP leaders, both at national headquarters and in H Division, took steps to ensure they understood the strengths and weaknesses in the RCMP's response to the mass casualty in order to make informed decisions about how to improve the RCMP's preparedness for future crises**. It became evident through the Commission's investigation that, more than two years after the event, RCMP leaders had done very little to systematically evaluate its critical incident response to the deadliest mass shooting in Canada's history.** Neither H Division nor national headquarters ensured a general after-action review of the response was carried out, despite internal requests for one. This section explores why an after-action review never materialized.

Overview of Relevant Roles in National Headquarters

For the purposes of the analysis that follows, it is necessary to briefly outline relevant areas of authority within RCMP national headquarters and, specifically, within Contract and Indigenous Policing.

Contract and Indigenous Policing is one of three main areas of RCMP policing, the other two being Federal Policing and Specialized Policing Services. The deputy commissioner of contract and Indigenous policing, D/Commr. Brian Brennan, is responsible for RCMP municipal and provincial policing across Canada. The commanding officers of each RCMP contract division, including H Division, report directly to D/Commr. Brennan. D/Commr. Brennan also sits with the RCMP commissioner and other senior leaders on the RCMP's Senior Executive Committee, which is "the highest level of policy, development and … approvals" in the RCMP.[34]

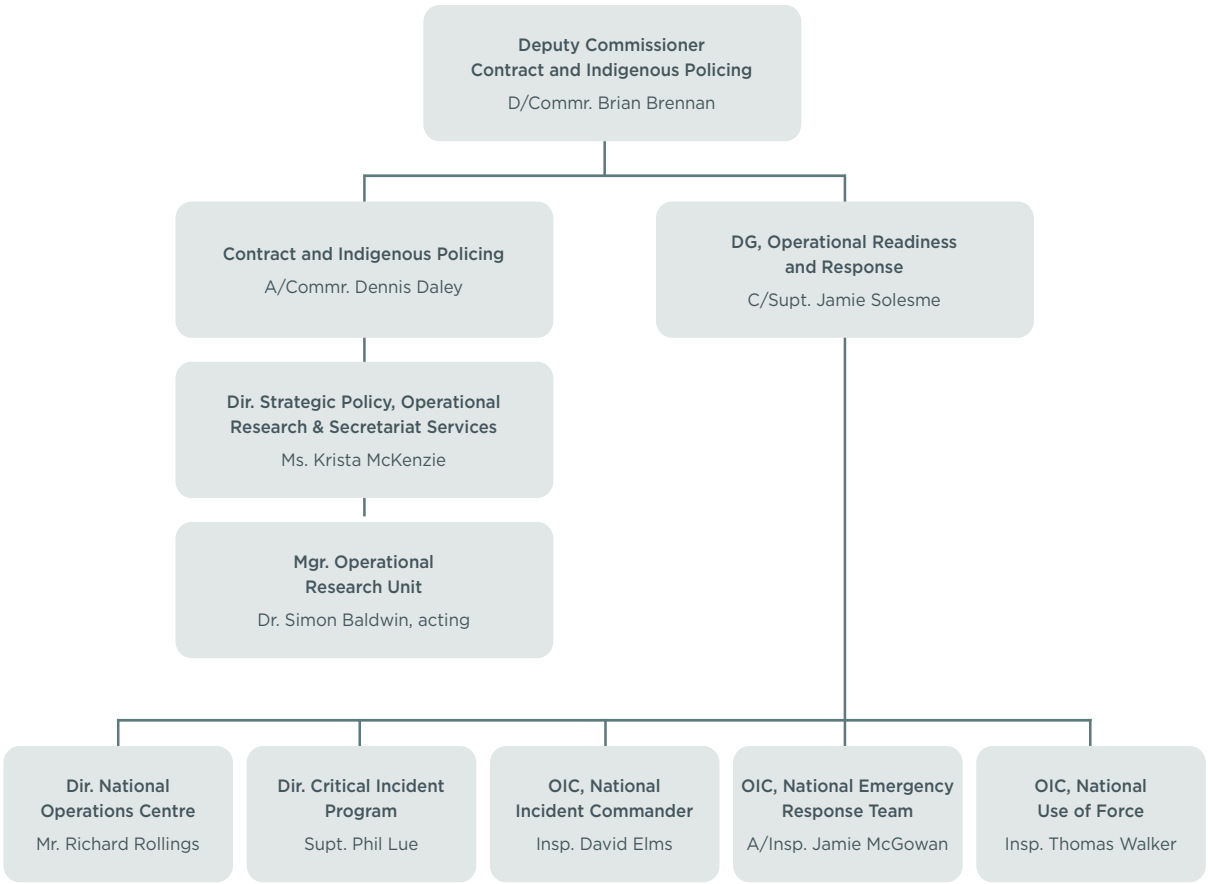
Reporting directly to D/Commr. Brennan is the assistant commissioner of contract and Indigenous policing. At the relevant times, this individual was A/Commr. Dennis Daley. (In December 2022, the RCMP announced that A/Commr. Daley had become the commanding officer of H Division as of October 28, 2022.)

In addition to overseeing the RCMP's contract divisions, Contract and Indigenous Policing has responsibility for several units or programs at national headquarters. One of those units is Operational Readiness and Response. The director general of operational readiness and response reports directly to the assistant commissioner of contract and Indigenous policing. At the relevant time, the director general of operational readiness and response was C/Supt. Jamie Solesme, who has since retired.

One of the programs within Operational Readiness and Response is the National Critical Incident Program. The director of this program reports directly to the director general of operational readiness and response. At the relevant time, the director of the National Critical Incident Program was Supt. Lue, who has since transferred from that position.

Also within Operational Readiness and Response are the officers in charge of the National Incident Commander Program, the National Emergency Response Team Program, and the National Use of Force Program. At the relevant time, the officer in charge of the National Emergency Response Team Program was Insp. Jamie McGowan, who has since transferred from that position. The RCMP's national headquarters organization chart usefully maps these various areas of responsibility.[35] Relevant portions of this chart are reproduced and adapted here.

RCMP National Headquarters Organization Chart: Contract and Indigenous Policing



Source | RCMP National Operations Centre Organizational Chart (27 June 2021): COMM0055929

Uncertainty from RCMP Executives About Relevant Policy Directives

Senior RCMP officers were uncertain about whether the RCMP had a policy regarding after-action reports or reviews regarding its critical incident response to a mass casualty. Commr. Lucki, who was "vaguely" familiar with policy regarding after-action reports, suggested:

> We normally often do a critical incident review, but sometimes when there's a bunch of different things happening, sometimes we will wait. The critical incident review, for example, or an after-action, can sometimes be done at any time.[36]

Commr. Lucki suggested that, in this instance, the decision had been "made to wait till many of these other reviews were done and see where the gaps are."[37] A/Commr. Bergerman testified that it was her understanding that the RCMP has a policy requiring the preparation of an after-action report after a major critical incident, and that pursuant to that policy, H Division (as opposed to national headquarters) would lead such a review. A/Commr. Bergerman explained that she did not initiate an after-action review or seek additional resources to permit such a review because "the investigation was the priority."[38] She also identified the need to "backfill frontline policing within the province" as a priority for her office,[39] explaining that the RCMP "had a number of members that were off duty and required some wellbeing to be addressed."[40] Finally, she identified that after the Mass Casualty Commission was announced, "what was explained to me, [was] that the critical incident response would be analyzed and examined here at the Commission and that it would be something that could be done afterwards."[41]

D/Commr. Brennan initially advised the Commission that the RCMP "definitely have policy around After Action Reports," requiring an after-action report to be completed following a major incident.[42] A subsequent letter from counsel for the RCMP clarified that the policy D/Commr. Brennan had in mind when he gave this answer related to exercises (in which the RCMP practices critical incident response, alone or in combination with other agencies). When D/Commr. Brennan testified, he explained, "I don't believe there is policy that specific. There is policy around the discretion of the Commanding Officers or the organization to undertake a review, so [an] independent officer review" similar to the MacNeil Report on the 2014 mass casualty in Moncton, New Brunswick.[43] No written RCMP policy about independent officer reviews was produced to the Commission. We therefore interpret D/Commr. Brennan's statement to mean that the commanding officer of a division, or the RCMP, has the discretion to commission a review.

Supt. Lue confirmed that the policy that D/Commr. Brennan initially alluded to does not apply to critical incidents such as the mass casualty. Supt. Lue explained that the RCMP has no policy requiring a general after-action report or after-action review for major critical incidents. Nonetheless, he said he would have expected that an after-action report would have been completed:

> [O]bviously some kind of After Action Report should be … completed … to take, those lessons learned to allow whether it's the RCMP or any other police force in Canada or around the world to learn from this and make sure that, hey, number one, did we do everything we could have done? … So, should there be an After Action Report? In my mind, I believe there should have been.

A/Commr. Daley similarly confirmed that no policy directs that an after-action review be conducted of a critical incident such as the mass casualty. However, A/Commr. Daley explained that the absence of such a policy certainly would not prevent the RCMP from reviewing its response. He pointed to the MacNeil Report as an example. A/Commr. Daley suggested that the discretion to commission this review rests with the commissioner of the RCMP. Other senior leaders suggested that the commanding officer of a division or the deputy commissioner of contract and Indigenous policing could order an after-action review. C/Supt. Leather suggested that H Division senior leadership, including the commanding officer or the criminal operations officer, could "champion" a review.[44]

Three key insights emerge from this evidence. First, there are no RCMP policy mandates that an after-action review be conducted after a major incident such as the mass casualty. There is also no policy requirement to conduct a general operational debriefing or prepare a general after-action report with those who have been involved in the critical incident response. **Second, months after the mass casualty, the RCMP's most senior leaders – who, as we will see, were actively involved in discussions about whether to conduct an after-action review – were unsure about whether RCMP policy required that an after-action review or report be completed. Third, even where policy does not require an after-action review or report, some senior leaders have the discretion to order one. However, senior RCMP officers differed in their evidence about whose responsibility it is to make that decision.**

A/Commr. Daley's Initial Proposal for an After-Action Review

RCMP national headquarters considered reviewing the RCMP's response to the mass casualty almost immediately after it happened. A/Commr. Daley initially advocated for this review. He believed it should be completed "within a reasonable

time afterwards, you know, whether it be a month afterward … but certainly not any, like not six months, not a year, that sort of thing."[45] Two days after the mass casualty, on April 21, 2020, A/Commr. Daley met with D/Commr. Brennan and recommended that the RCMP initiate a review. A/Commr. Daley told the Commission that his "recommendation from the get-go" was that either the RCMP commissioner or the deputy commissioner of contract and Indigenous policing should order a review of the mass casualty response.[46] D/Commr. Brennan asked his staff to research previous RCMP reviews before deciding whether to proceed. A/Commr. Daley's notes from this meeting indicate that D/Commr. Brennan would also speak to Commr. Lucki about this proposal "at some point."[47]

Consistent with D/Commr. Brennan's direction, over the next several weeks strategic advisors in Contract and Indigenous Policing conducted research about previous reviews, including whether the RCMP had implemented past recommendations. On May 27, 2020, A/Commr. Daley met with the H Division Issues Management Team[48] to discuss the proposed review among other matters.[49] Supt. Derek Santosuosso's handwritten notes from that meeting are partially redacted for litigation privilege but indicate there was "discussion around dealing with it quickly and addressing the expected recommendations so they are done immediately," but that the review was "not moving fwd yet."[50] A/Commr. Daley's notes of this meeting, which were provided to the Commission only after his interview with the Commission, are almost entirely redacted for solicitor-client privilege. On May 29, 2020, A/Commr. Daley wrote to C/Supt. Leather regarding the status of the proposed review. A/Commr. Daley stated that the background research requested by D/Commr. Brennan was expected to be complete by June 5, 2020, after which the deputy commissioner would be able to make a decision about whether or not to proceed with a review.

A/Commr. Daley told the Commission that he submitted research to D/Commr. Brennan but did not receive a response. Despite initially advocating for a review of the RCMP's response to the mass casualty, A/Commr. Daley stopped taking steps to move his proposal forward because he "didn't have any response back from my Deputy on, what the organization was prepared to do."[51] By the summer of 2020, A/Commr. Daley had abandoned his proposal for a review of the RCMP's response to the mass casualty. He noted that although it would have been his preference for the RCMP to conduct a timely review, he ultimately deferred to his superiors, whom he expected were involved in higher-level conversations about how the RCMP, as an organization, would respond in the aftermath of the mass casualty:

> Would I have preferred to launch an RCMP-initiated review? Yes. Led by an independent person, yes. That would be my preference. But I do recognize that I don't make all the decisions in the RCMP and I would expect actually conversations being taking place as to, that I'm not privy to, as to how the organization is going to react.[52]

H Division's Request for a Review in December 2020

While A/Commr. Daley deferred to the decision of his superiors not to direct an after-action review, H Division officers saw value in pursuing one. RCMP documents indicate that in December 2020, H Division began reaching out to Contract and Indigenous Policing to request that the RCMP conduct a review of its response to the mass casualty. (By this time, the Mass Casualty Commission had been established by the Canadian and Nova Scotia governments, by Orders in Council dated October 21, 2020.) It is unclear whether H Division senior personnel knew at that time that A/Commr. Daley had already unsuccessfully proposed an after-action review.

On December 14, 2020, C/Supt. Jamie Solesme received a call from Supt. Campbell regarding the possibility of conducting a review of H Division's Critical Incident Program and decision-making relating to the mass casualty response. C/Supt. Solesme wrote to A/Commr. Daley the next day, outlining her discussion with Supt. Campbell:

> Darren Campbell contacted me yesterday to discuss the feasibility of conducting an "independent assessment" of the Critical Incident Program in H Division. The review would focus on the CIP [Critical Incident Program] decisions made throughout the Portapique ordeal to determine the soundness and timing of decisions and to identify any apparent gaps. The review could also be extended to a phase 2 which would examine the program as a whole in H Division (not specific to the incident).
>
> If conducted, this review would [redaction for litigation privilege] and would provide valuable insight into the CIP. It would also demonstrate efforts by the RCMP to examine and improve any areas where deficiencies are noted.

> I am supportive and believe that this is something that Phil [Lue] could take on. Other reviewers could include someone from the Divisions, CPC [Canadian Police College], and/or another police agency such as the OPP [Ontario Provincial Police].
>
> I would like to solicit your thoughts on this as you are more engaged with other activities underway in the Division. If you believe this is something we should do, I will work to develop a terms of reference and identify reviewers.[53]

A/Commr. Daley replied to C/Supt. Solesme on December 16, 2020. His response is partially redacted for litigation privilege. In the portion produced to the Commission, he stated that his "first thought is whether the Public Inquiry will be doing this review."[54] He also noted concerns about the impact on employees of participating in multiple review processes. Despite these concerns, A/Commr. Daley did not reject H Division's request outright, explaining, "So I was not saying no to this. I was like, we need to have further conversation if we're going to actually do this."[55]

In the ensuing months, the Operational Readiness and Response Team discussed a potential review with C/Supt. John Robin, who had assumed the role of officer in charge of H Division's Issues Management Team in December 2020.

On March 26, 2021, members from Operational Readiness and Response, including C/Supt. Solesme, Supt. Lue, and Insp. McGowan, met with C/Supt. Robin, Supt. Campbell, and others to discuss the proposed review. Notes from the meeting suggest C/Supt. Robin told the group that the RCMP should not need to wait for the conclusion of the public inquiry in order to review its critical incident response. The notes record a discussion about several aspects of the proposed review, including the scope and the required expertise of the review team. A mandate letter was to be drafted, the review team would be selected by April 2021, and the work would be completed by May or June 2021.

On March 29, 2021, H Division submitted a formal proposal for the after-action review, including a draft mandate letter to C/Supt. Solesme. C/Supt. Solesme forwarded the request to A/Commr. Daley, noting she was seeking his support and approval in order to proceed.

On April 12, 2021, A/Commr. Daley wrote to C/Supt. Robin, Supt. Lue, and others reiterating his concerns about overlap with the Mass Casualty Commission and requesting additional information about the proposal. A/Commr. Daley's email states in part:

1. How does this review differ from the NS Mass Casualty Commission's review as they appear similar?
2. I assume this review is to take place prior to the Commission Review? [redactions for solicitor client privilege]
3. What is the expected timeline to complete this review? The results then will [be] available to be disclosed to the Commission?
4. Is there a lead identified to take this on and coordinate?
5. Is there a communications strategy to support this?
6. Anticipated costs are not listed in the document. Any comments on that?
7. Has your CO [commanding officer] discussed this already with the deputy [Commissioner]?[56]

On April 21, 2021, A/Commr. Bergerman wrote to D/Commr. Brennan in an attempt to move the H Division proposal forward. A/Commr. Bergerman's email enclosed a document with answers to the above questions posed by A/Commr. Daley. That document, partially redacted for litigation privilege, states in part:

> Following the police response to any major serious incident, initiating a review of police actions and decision making is considered a best practice. The Mass Casualty Commission, (MCC) has a mandate to complete an interim report by May 2022 and a final report by November 2022. As a police agency dedicated to continuous improvement, the RCMP cannot wait for the Mass Casualty Commission to complete its' work, before conducting an internal review of the police response and initiating changes, if changes are required.
>
> The RCMP would have been quite rightly subject to criticism, if the Force had waited for the MCC to review and initiate changes to policies and procedures in areas such as public alerting and, uniform and equipment disposal. Similarly, should the Critical Incident Command (CIC) internal review of the police response identify gaps and areas for development, **initiating change now is the responsibility of the RCMP, rather then waiting for direction from the MCC to do so.**[57]

On May 3, 2021, A/Commr. Daley emailed C/Supt. Robin and C/Supt. Solesme to advise them that D/Commr. Brennan was "not opposed to this review" but he did have additional questions requiring response from H Division before final

authorization could be sought.[58] These questions are set out in the email, which is partially redacted for litigation privilege. C/Supt. Robin replied that he would "follow up asap."[59]

On May 26, 2021, an email from "C&IP tasking" advised that H Division's proposal and draft mandate for the review (submitted by C/Supt. Solesme on April 9, 2021) "were returned to ORR [Operational Readiness and Response], without A/Commr. approval."[60] The email contemplates that an updated proposal would be submitted for approval, stating, "Please advise if I can file this email, and wait for the updated version to track and move up for approval."[61] C/Supt. Robin was subsequently removed from his role in the Issues Management Team on the basis of concerns about a perceived conflict of interest. This course of events is discussed further in Chapter 10 of this volume.

A/Commr. Daley explained in an interview with the Commission that he was expecting a finalized proposal but never received one:

> COMMISSION COUNSEL: So at some point after May, the questions are answered and were the questions answered to the satisfaction of yourself and Deputy Commissioner Brennan?
>
> A/COMMR. DENNIS DALEY: Yes. Yes. Yes, they were. Yeah, but, but you know, they were, but we'd have to, then really define what we're going to do and how we're going to do that. ... it would be my normal course of business that I would run the mandate letter by the Deputy for his awareness; whether he communicates it further, that would be his prerogative. But I certainly wanted him to be aware that what we were going to do, when we're going to do it, who was going to do it, that sort of thing. So, but those weren't the nature ... the questions ... the questions are basically laid out there in number 1 as to what the questions were. **So but again, they were answered, yes, but the final product, I never saw the final product.**[62]

It appears that by July 5, 2021, in addition to H Division's proposal, the Hazardous Occurrence Investigation Team (HOIT) had made an interim recommendation for the RCMP to complete a critical incident review. Again, however, despite ongoing discussions, no finalized mandate letter was completed, and no review was launched:

> A/COMMR. DENNIS DALEY: … the HOIT made some sort of interim recommendation to complete a Critical Incident review.
>
> COMMISSION COUNSEL: What happened after this SitRep? So again, what happened after July 5, 2021?
>
> A/COMMR. DENNIS DALEY: After July of 2021, again, it falls within the purview of Jamie Solesme, assigned to Superintendent Phil Lue, again looking for, I'm aware that he was looking for Critical Incident Commanders across the police universe and I'd be getting briefs via Jamie Solesme that, that's the intention. But again, no finalization of a mandate letter or actual plan to launch the actual review was ever done.
>
> …
>
> A/COMMR. DENNIS DALEY: I thought it was progressing. I knew we weren't at the point of launching. I knew it was progressing. I knew that Phil [Lue] was trying to identify the CIC's and working towards a mandate letter. And, but I did not take any overt actions to say I want it done or I want a mandate letter on my desk tomorrow morning. I did not do that, no.[63]

RCMP notes and emails indicate that in December 2021 and January 2022, Supt. Lue was making efforts to secure a team of subject matter experts to conduct the review and refine the scope of the review. Notes from a meeting on January 13, 2022, are significantly redacted for litigation privilege. However, the portion visible to the Commission suggests that Supt. Lue was "working on putting a group together" to conduct the review.[64] The team would include a member of the Ontario Provincial Police, a retired police officer, and an RCMP member from K Division (Alberta). The notes suggest that Supt. Lue was still waiting for a final approval to proceed, stating, "Once he gets the group together and have the ok, they will make their way to NS."[65] These notes were disclosed to the Commission only after the close of its proceedings. Commission counsel was therefore unable to ask witnesses about the status of the review coming out of this meeting.

The review did not proceed. RCMP senior officers gave varying accounts as to why. As noted, A/Commr. Daley said that he was simply waiting for a finalized proposal that he never received. He attributed this at least in part to Supt. Lue's January 2022 deployment to protests then taking place in Ottawa and to C/Supt. Solesme's retirement. However, C/Supt. Leather's understanding was that the proponents of the review never submitted a finalized mandate letter because they knew it

would be rejected by decision-makers at national headquarters. He believed the proposed review "died on the vine."[66] Insp. Moser also recalled learning from Supt. Campbell that the request for an after-action review "wasn't supported" by national headquarters.

C/Supt. Campbell testified that the proposed review was a point of "impasse" between him and Ottawa:

> PARTICIPANT COUNSEL: … Look, the Commission is going to try to do its best, everybody would agree with that, I think, but these things take time and we're over two years since this incident took place. There's no review by the RCMP. Isn't that unacceptable?
>
> C/Supt. DARREN CAMPBELL: For me it is, and that's the basis for why I was at an impasse and a disagreement with Ottawa.[67]

Supt. Lue told the Commission that he received changing directions from his superiors, who appeared to go back and forth about whether or not they were prepared to do a review of the critical incident response. This back and forth persisted until he left the National Critical Incident Program at the end of August 2022:

> SUPT. PHIL LUE: I heard from my boss, my Chief Superintendent Jamie Solesme, they want to do this report, H Division's asking for it, we don't know who's going to do it, we don't know if it's actually going to go right now. **So, then, it was kind of sidelined for a bit and then it was back on and then it was sidelined for another time and then it was like it literally … it went back and forth and back and forth.** I remember talking to my wife saying like, "This is ridiculous. Like either we're going to do this or we're not going to do this." … just tell me if it's either we're going or we're not going. I … **I can't deal with the, "Hey, we're going. No, we're not going. Oh, we're going to have more discussions. Oh, we're not." And then I'm not … I was never privileged to those discussions, right.** So, I wouldn't have been in the discussions with … with Chris Leather and Darren Campbell and those guys. Not that I don't know them, not that I wouldn't be happy to talk to them, but those discussions are being had up here and I am kind of waiting here.
>
> …

> COMMISSION COUNSEL: Then you describe sort of the back-and-forth process of whether it was going to go ahead or not. Do you recall how long that back and forth carried on for?
>
> SUPT. PHIL LUE: Until a month ago, when I left.[68]

Supt. Lue explained that it was frustrating and at times embarrassing to have lined up experts from other police services to conduct the review, only to have to tell them that the review was put on hold:

> COMMISSION INTERVIEWER: What were you told about like, why it didn't go ahead or why there was hesitation to have it go ahead?
>
> SUPT. PHIL LUE: I wasn't really given a reason. There's … a lot of times in these meetings there's not a lot of explanations. Something that I kind of struggled with in Ottawa, because in the Contract world, somebody kind of ranks above me would tell me something and I'd be like, "Why? I want to know why." And somebody would tell me and I'd be like, "Okay, that makes sense." **But a lot of the kind of back and forth would be, you know, "Hey, Jamie [Solesme], what's going on with this? Are we doing this review or not?" "Yeah, it's still in discussions.** I'll … I'm going to talk to Dennis [Daley]. I'll let you know," and then that's it. So, like I said, it was frustrating for me. **So, after like, three or four times asking and actually going and talking to, like, colleagues and kind of lining stuff up and then having to tell them, "Yeah, we're … we're on hold," it's kind of embarrassing.** So, I would just like, I'd ask, I'd say … they'd tell me that it was … they're having discussions. "Okay, sorry.[69]"

Supt. Lue told the Commission that he tried to push the review forward but was not supported by his superiors:

> [A]nd maybe when I think back about it that now, I was thinking about it yesterday, and did it … is it my fault that I kind of failed, like H Division, in not getting this thing done? **Could I have pushed more? I probably couldn't have; I probably couldn't have made them do this even from my position, because, as a Superintendent in the RCMP, when you're dealing with a bunch of people that outrank you and that have all kinds of discussions that I'm not privy to, I'm pretty sure I made it very clear and probably not why … probably why I'm not working remotely for them**[70]

> **is I spoke my mind** … I think that's just how those things in Ottawa work is, you will get told when you need to get told and otherwise if you ask questions, you … you probably won't get answers. It's unfortunate.[71]

The culture that Supt. Lue describes in this passage has also been documented in other reviews of the RCMP. In Chapter 10, we return to the ways in which RCMP management culture hinders the organization's ability to learn and improve.

The fact that the RCMP had not conducted an after-action review of its critical incident response arose in the Commission's process via witness testimony and interviews. This evidence prompted C/Supt. O'Malley to follow up with Supt. Lue about the status of the proposed review. In a July 6, 2022 reply to C/Supt. O'Malley and C/Supt. Solesme, Supt. Lue stated that the review did not go ahead because it was determined "not to be feasible, nor readily accepted by those involved."[72] He referred C/Supt. O'Malley to C/Supt. Solesme and A/Commr. Daley for any further follow-up.

A/Commr. Daley disagreed that the review was 'on again-off again' as Supt. Lue described. However, he understood why it appeared that way from Supt. Lue's position:

> I wouldn't characterize it as stopping and starting. I would say it was, it … and I, but I can understand [Supt.] Phil [Lue]'s perception of that because H Division had come in, had initial discussions, they go back to the drawing board, then they come back in. Then we have initially further discussions, talked with Deputy Commissioner Brennan. No, I don't know all the communications back to [Supt.] Phil Lue, but I can see him as an interested party wondering what is going on and when so he interprets off and on, I wouldn't interpret it that way, I would be saying we're seeking further clarity. How are we going to define that, that sort of thing? So [Supt.] Phil [Lue]'s not wrong, perhaps in his perception of what was taking place.[73]

A/Commr. Daley acknowledged in his interview that while he may not have communicated a firm "no," neither did he ever make a decision to go forward with the review:

> A/COMMR. DENNIS DALEY: There was never a decision made, and I say this categorically, there was never a decision not to do it. **You know, there**

> **was never a decision … like there was never a launching of it either. So I can take responsibility for that part.**[74]

Like A/Commr. Daley, C/Supt. Solesme stated that, to her knowledge, there was never a decision *not* to proceed with the review. She said she never advised Supt. Lue to stop preparing for the review. She believed Supt. Lue had difficulty fitting in work on the review among competing priorities, including his deployment in January 2022 as the RCMP lead in the Integrated Planning Cell for the protests then taking place in Ottawa. It is nonetheless clear from her affidavit that, despite expectations for ongoing preparation by Supt. Lue, C/Supt. Solesme never received confirmation from A/Commr. Daley about whether he and his superiors were prepared to go forward with the review:

> It should be noted that as the [director general] of ORR, I never directly received, in writing or verbally, any indication from senior management of support or non-support for us to undertake the review. **In my discussions with A/Commr. Daley he was unable to provide me a clear decision from his superiors with respect to advancing the review.**[75]

Commr. Lucki's and D/Commr. Brennan's evidence on this point differed from that given by A/Commr. Daley and C/Supt. Solesme. The commissioner and deputy commissioner suggested that national headquarters did in fact decide not to proceed with H Division's proposed review – at least until after the Commission and other investigations related to the mass casualty had concluded. Commr. Lucki described this as placing the proposal in "abeyance."[76] D/Commr. Brennan similarly stated that national headquarters decided against proceeding with the review at the time it was requested, although that decision did not preclude headquarters from carrying out a review at a later date. As noted, A/Commr. Daley and C/Supt. Solesme did not mention any decision to place the proposed review in abeyance, or otherwise call it off. They were evidently not privy to this decision.

H Division senior officers as well as C/Supt. Solesme and Supt. Lue were supportive of a review. D/Commr. Brennan had concerns about whether to proceed with a review, and although he characterized his contributions as *advice* or *discussion* rather than *direction*,[77] it is clear that A/Commr. Daley would not have authorized this review without the deputy commissioner's full support:

> A/COMMR. DENNIS DALEY: … So however, so in reference just to close the loop in reference to Deputy Commissioner Brennan, so yes, I believe

> it would be within my purview to initiate this sort of Critical Incident Review; yes. I would not have done it without his knowledge however, and his, his consultation, because just of the implication that we now had the Federal Government involved, the Provincial Government, we had the Mass Casualty Commission, we had … so I would not have done it in secret, let's say; I would make sure he was fully aware and supportive.[78]

Although D/Commr. Brennan characterized the decision not to proceed with an after-action review as one that was "made by others,"[79] he agreed that he had the discretion to order a review had he chosen to do so.

The decision not to proceed with an after-action review, or to put such a process in abeyance, was not communicated or explained to H Division leadership or the Operational Readiness and Response Unit. The reasoning behind the RCMP's hesitation remains unclear to this Commission. Concerns about overlap with the Commission's process and *Canada Labour Code* investigations evidently played a role, but the Commission was ultimately unable to gain a clear picture of the RCMP's decision-making on this issue. This result is partially due to late production of relevant documents from the RCMP. Many emails and notes related to the proposed critical incident review were not provided to the Commission until after the relevant witnesses were interviewed or had testified. Commission counsel and Participants therefore did not have access to relevant documents when questioning witnesses about the RCMP's decision-making on this issue. Further, many of the RCMP's emails and meeting notes regarding the proposed after-action review were partially redacted for litigation privilege. Ultimately, it was not possible for the Commission to fully understand why the RCMP decided not to proceed with a review of its critical incident response despite an evident desire within the organization to do so.

Absence of an After-Action Review Surfaces in the Commission's Process

From June to September 2022, various senior RCMP officers attended interviews with Commission staff and testified at the Commission's hearings. The RCMP's failure to conduct a review of its response in the two years following the mass casualty was the subject of questioning during this period, reinvigorating discussions at RCMP national headquarters regarding the need for a critical incident review. By

the time A/Commr. Daley was interviewed, on September 15, 2022, the RCMP had begun taking steps toward conducting a limited review of its response to the mass casualty. A/Commr. Daley. acknowledged that scrutiny during the Commission's proceedings drove the RCMP's renewed interest in a review:

> A/COMMR. DENNIS DALEY: Was I … I was certainly aware of the lack of … that the Critical Incident Review became one of the central points in the Commission. Yes, I was certainly aware of that. If you're asking, was there any discussion we would have weekly updates on the status of the Review the status of the Commission, the issues surfacing during the Commission. There was conversation there. We certainly knew the Commission's interest in this. So the only, the only time that Deputy Brennan, in fact, called me … what's today? Today's Thursday. I think he called me Monday post his testimony and we spoke of the need to complete the Critical Incident Review, which, I had intentions … if I would still be here, I would have intentions of completing because one would have to be looked at; no doubt it would be a recommendation from the Commission. So we spoke of doing the review, hence my meeting for Friday set tomorrow to scope with my new resource that's coming in at the end of the month, scope of what the review would look like. So that would be the nature of the discussions, I guess.
>
> COMMISSION COUNSEL: Would it be fair to say that a significant factor in you and others now looking at this issue of the Review is, in fact, the scrutiny that this Commission has put on that issue? Is that fair?
>
> A/COMMR. DENNIS DALEY: I would agree with that but I would also do a bit further, and say it's the right thing to do …
>
> COMMISSION COUNSEL: And then when we look at this more limited review that you're going to have a meeting about tomorrow, isn't it fair to say, Assistant Commissioner, that that more limited review really did fall off the table until the issue more generally of a review was resurrected in this Commission over the last couple of months? Is that a fair statement?
>
> A/COMMR. DENNIS DALEY: Yes, cert– … yes, that's a fair statement. Yeah, that's a fair statement[80] …

Conclusion

Earlier in this volume, we identified that a key principle of effective critical incident response is to implement institutional processes to review and learn from past incidents in order to improve future performance. We pointed to examples of international reports such as the Orlando Pulse nightclub after-action review in the United States and the Norwegian Gjørv Commission report, which demonstrate the potential of after-event learning processes to produce lessons that can assist both the agency under review and similar organizations. As we have seen through this Commission's work, the lessons learned from critical incident response aren't specific to the responding agencies or where the incident took place. The public is owed not only the exercise of a review but also the sharing of lessons learned with the broader international community to help keep us all safer. Although the RCMP has on occasion conducted structured post-incident reviews – for example the MacNeil Report – such reviews are not required by policy or by the RCMP's accountability mechanisms. Nor does the RCMP have a standard practice of operational debriefing, or of ensuring that the insights of general duty members, employees of the Operational Communications Centre, and others are elicited in the service of improving future responses.

After-action reports about the work of the Emergency Response Team and the Emergency Medical Response Team were drafted but not formally submitted to RCMP management in accordance with normal protocol. The decision not to submit these reports was taken against a background of conflict between the Emergency Response Team and H Division leadership, in particular. We discuss this conflict in greater detail in Chapter 10.

In this chapter, we have traced the efforts made by RCMP personnel to identify and document the lessons that emerge from the RCMP's critical incident response to the mass casualty. We have found that several RCMP members, including senior officers, advocated for an after-action review to be completed. However, for reasons that are not clear, the decision was taken at a senior level to put such a review into abeyance until after this Commission was complete and perhaps until after other investigations arising from the mass casualty had also run their course. D/Commr. Brennan said that to the best of his knowledge, this decision was not driven by concerns about liability.[81] We agree with A/Commr. Daley and Ret'd. A/Commr. Bergerman that an after-action review should not be delayed by months or even years. As Supt. Dimopoulos observed in an interview with the

Commission, "the earlier the better, simply because memories are fresh. There is momentum. There are a lot of questions that are being asked by the families and by the public that beg for answers."[82]

A timely assessment of responses to critical incidents helps not only those involved in that particular response but also those who will respond to the next one, whether the same people in that place or others, elsewhere. Lessons learned from any one mass casualty can be reviewed and applied so that those responding to the inevitable next mass casualty have the benefit of those insights. Indeed, there have been several mass casualties in Canada and internationally since April 2020. Waiting months or years to conduct an after-action review serves no one.

Other Canadian police services have, in the past, conducted comprehensive reviews of their institutional actions while other legal proceedings – and even public inquiries – are anticipated or in process. An important example of this practice is provided by the Vancouver Police Department's (VPD's) 2010 review of its investigative response in the case of a serial killer who targeted women in Vancouver's Downtown Eastside. Deputy Chief Constable Doug LePard examined all facts of the department's work in this case in a lengthy report that identified many shortcomings and lessons learned. That review concluded, for example, that the "VPD should have recognized earlier that there was a serial killer at work" and that an investigation team tasked with investigating missing women "suffered from a lack of resources, poor continuity of staffing … and a lack of leadership, among other challenges."[83] The LePard Report also pointed to challenges arising from the patchwork of police agencies in the Lower Mainland of British Columbia, with the RCMP holding jurisdiction over the place where the serial killer committed his murders. This report was made public and became an important source for British Columbia's Missing Women Commission of Inquiry, which described the report as a "thorough review" and a "comprehensive evaluation."[84] In his final report, Commr. Wally Oppal accepted many – but not all – of DCC LePard's conclusions. It seems likely that, had the RCMP conducted and published a similarly comprehensive after-action review, some of this Commission's findings and recommendations would have been addressed by the organization well before the publication of our Final Report.

Incoming H Division Commanding Officer A/Commr. Daley acknowledged that the RCMP's failure to review its critical incident response in a timely manner has impacted public confidence in the RCMP:

> [Y]ou had earlier asked me about was a reputational loss and public trust loss? Yes, I believe there was. I believe Nova Scotians expected their police service to review our response, and I would have expected to do that. That would be my expectation. And we would have to be transparent and in launching that review and responding and communicating that review, much like I think MacNeil was communicated and, that sort of thing. So yes, I believe that the larger MacNeil like review may be too late for the RCMP to do.[85]

LESSON LEARNED

Operational debriefs and after-action reports provide an invaluable means of capturing lessons learned from a critical incident response. It is important to include all responding members in these processes.

Recommendation P.23

OPERATIONAL DEBRIEF AND AFTER-ACTION REPORT

The Commission recommends that

The RCMP should implement policies and procedures to require an operational debrief and after-action report for any critical incident response that required the active engagement of a critical incident commander.

IMPLEMENTATION POINTS

The policies and procedures should include the following:

- The commanding officer of the division will direct in writing that the operational debrief process is engaged and assign a commissioned officer to oversee the completion of an operational debriefing and to prepare an after-action report.

- A supervisor who possesses the skills and training to conduct operational debriefings will be assigned to facilitate these sessions, and the debriefing will include all employees who played a part in a critical incident response.
- A written summary of the operational debrief must be submitted by the assigned supervisor of the operational debrief to the commissioned officer who has been appointed to oversee this process and produce the after-action report.
- A comprehensive after-action report should be produced by the assigned commissioned officer. This after-action report should highlight any risk areas for immediate action.
- The after-action report should be submitted to the commanding officer within 30 days of the event occurring. In the event that the 30-day timeline is not met, approval in writing is required by the commanding officer with a stated due date.
- The commanding officer should address any risk areas identified in the after-action report for immediate action, including any updates to relevant policy, procedures, and training, as soon as practicable. Reporting on implementation of these items should be a standing item on monthly bilateral meetings so that progress can be monitored and roadblocks addressed.
- The after-action report and a written response from the commanding officer should be shared within 60 days of the critical incident with every employee who participated in the critical incident response, with the RCMP Operational Readiness and Response Unit, and with the deputy commissioner of contract and Indigenous policing for their situational awareness and institutional review.
- Where the commanding officer or deputy commissioner of contract and Indigenous policing identifies the need for an after-action review, that review should be commissioned within 90 days of the critical incident. A copy of the after-action report and written summary of the operational debriefing should be shared with the independent reviewer.

Recommendation P.24

PUBLIC REPORTING ON CRITICAL INCIDENT RESPONSE

The Commission recommends that

The RCMP should prepare and publish an annual report that explains what the RCMP has learned from operational debriefings and what changes it has made in response to after-action reports in the previous year. This report should provide an amount of tactical and operational information similar to that provided by other agencies; for example, ALERRT (Advanced Law Enforcement Rapid Response Training) Center reports and (US) National Policing Institute reports such as the Orlando Pulse nightclub report.

Recommendation P.25

AFTER-ACTION REVIEW OF MASS CASUALTY INCIDENTS

The Commission recommends that

Within 90 days of a mass casualty incident occurring, the RCMP should initiate an after-action review to be conducted by an arm's length reviewer.

IMPLEMENTATION POINTS

- This review should be commissioned by the deputy commissioner of contract and Indigenous policing and should supplement, not replace, the process set out for operational debriefings and after-action reports.
- The after-action review should be completed and published within six months of being commissioned. If this deadline cannot be met, the RCMP should provide a detailed public rationale.
- After-action reviews should provide a similar amount of tactical and operational information to that provided by agencies in other jurisdictions; for example, in ALERRT (Advanced Law Enforcement Rapid Response Training) Center reports and (US) National Policing Institute reports such as the Orlando Pulse nightclub report.

CHAPTER 6

RCMP Public Communications and Internal Relations After the Mass Casualty

CHAPTER 6 RCMP Public Communications and Internal Relations After the Mass Casualty

In the days and weeks after April 18 and 19, 2020, the mass casualty was the leading Canadian news story for mainstream media outlets. It also received international media attention. In Volume 2, What Happened, we provide a detailed account of the RCMP's public communications after the mass casualty. We identify public communications in which the RCMP did not share information then known to it and instances in which incorrect information was provided. For example, the number of casualties stated by RCMP representatives on the evening of April 19 varied, from more than 10, to 13, to 17. At that time, internal RCMP documents show that investigators had confirmed 17 deaths.[1]

Some degree of uncertainty was to be expected in the immediate aftermath of the mass casualty, and the media was initially understanding about the challenges facing the RCMP as it commenced its investigative work on multiple complex crime scenes across a wide geographic area. Given gaps in the information provided by the RCMP, journalists turned to other sources, particularly community and family members, to understand the chronology of the mass casualty, identify victims, learn more about the perpetrator, and describe the RCMP's critical incident response. As concerns arose about seemingly changing or incomplete information being provided by the RCMP, media and public scrutiny began to focus on the quality of the RCMP's critical incident response and its public communications practices during and after the mass casualty. Family and community members started to express their frustration publicly at the relative lack of information being shared by the RCMP. For example, Nick Beaton, the spouse of Kristen Beaton, who was expecting a child at the time she was killed by the perpetrator on April 19, was quoted by the Canadian Press on April 27: "We don't know anything because they're not telling us."[2] **Despite considerable organizational focus on public communications, the RCMP struggled to provide timely and accurate information to the public after the mass casualty.**

In this chapter, we describe the RCMP's policy guidance with respect to public communications before evaluating the RCMP's public communications in the days immediately after the mass casualty. We identify that H Division leadership and communications personnel experienced considerable personal and professional strain in the aftermath of the mass casualty and that a request made by H Division's director of strategic communications for more support went unfulfilled for some weeks after it was made. At the same time, the RCMP's most senior leaders, particularly Commr. Brenda Lucki and D/Commr. Brian Brennan, were concerned by what they perceived to be inadequate internal briefing practices and poor public communications.

These dynamics came to a head in the teleconference of April 28, 2020, among nine senior RCMP personnel, five from national headquarters and four from H Division. During this meeting, Commr. Lucki expressed her disappointment and frustration about how public communications and internal briefings had been managed in the days since the mass casualty. We assess the evidence we heard about this meeting and its immediate and long-term impact on H Division personnel. Finally, we explain how the failure to address the ramifications of the meeting contributed to a breakdown in trust and in relationships between H Division and national headquarters.

RCMP Communications Policies

Policy directives related to public communications are found in several chapters of the RCMP's national operational and administrative manuals. "Media Relations," Chapter 27.1 of the *Operational Manual*, sets out general principles to the effect that the RCMP must foster productive media relationships but avoid releasing information that could compromise investigations or individual rights. It instructs that public communications should "[c]onfirm the obvious by covering the 5Ws (who, what, when, where, why), and 'how' of situations without identifying individuals."[3] The policy also directs RCMP employees not to "express their personal comments publicly or criticize the RCMP, partner agencies, government departments, or provincial and federal legislation when dealing with the media."[4]

"Media Releases," Chapter 27.2 of the RCMP *Operational Manual*, sets out further directives. This policy provides more specific guidelines about what information should *not* be released to the public. It states, for instance, that the RCMP must ensure that information released to the media does not do any of the following:

> 1.1 Interfere with an investigation or arrest;
>
> 1.2 Reveal police methods of investigation or security measures taken in the protection of property or persons;
>
> 1.3 Result in injury, injustice, or embarrassment to the victims or the accused;
>
> 1.4 Result in publicity that could affect the course of a trial;
>
> 1.5 Contravene the provisions of the RCMP Act, Privacy Act, Access to Information Act, Canadian Charter of Rights and Freedoms or Canadian Human Rights Act[5]

The media releases policy also provides that the RCMP must never release the name of a suspect before charges are laid. It states further that RCMP employees must "[r]eport only the facts" and refrain from speculating or offering personal opinion.[6] In addition, the RCMP must not release the names of young persons or injured persons, and must not disclose the cause of death before an autopsy and determination by a medical examiner.

Public communications are also addressed in "Human Deaths," Chapter 41.3 of the RCMP's *Operational Manual*. This policy refers to the limits on public disclosure imposed by the *Privacy Act* and the next of kin notification process. Among its provisions are directives to "[c]onfirm with the coroner / medical examiner that the identity of the deceased has been verified, and that their name may be released."[7] It also directs members that they may publicly release the name of deceased persons only after next of kin notification, and then only in certain specified circumstances.

Chapter 25.3 of the national *Operational Manual* deals with the role of the team commander of the Major Case Unit with respect to media and public communications. The team commander is the person who holds "overall authority, responsibility, accountability and control" of a major case investigation.[8] Clause 5 of the policy states that the team commander "will ensure that a media strategy is in place for all major cases" and that the team commander must approve all media releases before release.[9] It also provides that the divisional media relations officer must "gather relevant information regarding any national or potential national /

international issues and brief National Communications Services" at a specific email address.[10] Chapter 25.3 also provides for internal briefing processes. Regular reporting to the divisional criminal operations officer is required for all major cases, and for "significant, high-profile or high-risk incidents," national headquarters must be advised "by the most expedient means."[11] Chapter 46.1 of the national *Operational Manual* contemplates that the usual means of briefing national headquarters is via a situation report – a short briefing note distributed by the RCMP National Operations Centre to a specified set of recipients.

"Media Inquiries," Chapter 27.3 of the *Operational Manual*, also states that divisional communications staff must brief the national director of media relations. It similarly directs that "[a]n approved media strategy will be devised," although neither Chapter 25.3 nor Chapter 27.3 states who is responsible for developing the strategy.[12] According to Chapter 27.3, this strategy should set out the following information:

> 1.3.1 assigned national / international and regional spokespersons and their briefing updates;
>
> 1.3.2. media lines and any modifications;
>
> 1.3.3. news releases and media advisories;
>
> 1.3.4. other government department and stakeholder briefings; and
>
> 1.3.5. news conferences.[13]

The media inquiries policy also states that "[a]ll information released to the media must present the views of the RCMP and any of its partner stakeholders."[14] Finally, it directs the RCMP to review its media response for lessons learned before closing the file.

A further chapter of the *Operational Manual*, Chapter 27.4, "News Releases and Conferences," provides additional instructions. Sections 1.1 to 1.5 of the policy address news releases. Sections 2.1 to 2.7 deal with news conferences. The policy provides that news conferences are used "to communicate new and important messages about a significant event or to reveal information about complex investigations, police operations, and community partnerships and initiatives."[15] It states that "a news conference will focus media attention, save time by reducing the number of individual interviews, get the information out to all media simultaneously, and avoid the perception of favouritism to certain reporters."[16] It also includes provisions relating to requirements to provide information in both official languages. After the

report written in December 2014 by Ret'd. A/Commr. Alphonse MacNeil, following the mass casualty in Moncton earlier that year when the lives of three members of the RCMP were taken and two were injured, the RCMP added section 2.7, which states that "[w]hen feasible, use a subject matter expert as a spokesperson, during news conferences, to explain any operational perspective that can be shared with the public."[17]

In addition to these chapters of the *Operational Manual*, the national RCMP *Administration Manual* contains further directives on public communications. Chapter XIII.1, "Communication Services," provides general guidelines to the "RCMP communications community."[18] For instance, it directs the "RCMP communications community" to "provide quality information to its audiences that is timely, accurate, clear, objective and that complements the RCMP's policies, programs, services and initiatives."[19] It also states that communications should "ensure that the RCMP is visible, transparent, accountable, and accessible to the public and the audiences it serves"[20] and safeguard "the public's confidence and trust in the RCMP."[21] An additional provision directs the RCMP to work "collaboratively with its government and public partners to achieve coherent, comprehensive and consistent communications to its audiences."[22]

These national policies do not offer concrete guidance for communicating effectively with the media and the public about critical incidents. Nor do they set out a clear hierarchy of objectives for the RCMP's public communications about major events or demarcate the responsibilities of divisional and national communications staff. While the policies identify that the principles guiding public communications include transparency and accountability, no direction is given about how to follow these principles or how to resolve conflict among potentially competing values such as the need for objectivity and the obligation to present "the views of the RCMP."

As is true with many of the RCMP policies we reviewed, the relevant provisions are set out across numerous chapters and across more than one manual. This practice raises a risk of internal contradiction or gaps arising in policy and makes it difficult to be certain that one is complying with policy. **Throughout our work, RCMP employees – including senior officers – tended to refer in general terms to RCMP policy. However, they were often uncertain about whether a policy applied to a given situation, what steps it required them to take, or even which manual contained the relevant policy. Some context for this uncertainty is provided by the fact that the national RCMP policy binders we created on the basis of materials**

that the RCMP produced to us, which contained only those policies that were in force on April 18 and 19, 2020, and relevant to the Commission's mandate, ran to 4,976 pages. The H Division policy binder, assembled in accordance with the same principles, was a further 929 pages in length. The unfortunate result of this abundance of policy is a widespread lack of knowledge within the RCMP of the requirements of RCMP policies, even at the most senior ranks. In any circumstance, but especially given this difficulty, well-drafted standard operating procedures have the potential to provide much-needed clarity.

Past reviews of the RCMP have called for improvement in the organization's public communications practices. In 2007, *Rebuilding the Trust*, the Report of the Federal Task Force on Governance and Cultural Change in the RCMP chaired by David Brown (Brown Task Force Report), concluded that "[t]he RCMP has been unable to balance legitimate privacy and liability concerns with the need for openness and transparency."[23] It observed systemic weaknesses in communications, both to the public and from management to members, including slowness, lack of transparency, and inaccurate information, and made recommendations including that the RCMP adopt "a crisis management strategy that will permit quick and accurate responses to the media and Canadians."[24]

In 2010, a Reform Implementation Council that was formed to oversee the RCMP's response to the Brown Task Force Report observed in its final report, *From Reform to Continuous Improvement*, that "[t]he RCMP has not moved aggressively enough to meet the internal and external communications needs of the Force."[25] The council called for a more strategic, open, and transparent approach to internal and external communications and noted in particular that "the critical question of who makes which decisions on specific communications issues – NHQ [national headquarters], Division or Detachment – remains to be adequately addressed."[26]

With respect to H Division specifically, the Commission for Public Complaints against the RCMP concluded in its *Report into the Death of John Simon* that the RCMP's media responses in relation to the incident were inadequate and could have misled the public. Further, RCMP responses prepared for briefing Cape Breton's Wagmatcook First Nation (of which Mr. Simon was a member) and family members omitted information. The commission concluded that "the actions or lack thereof of the members responsible for making decisions relating to discipline, and also of those responsible for conveying information to family members and the public, negatively impacted public perceptions and in turn public confidence in the RCMP."[27] The RCMP's public communications were also the subject of adverse

findings in the 2010 Report of the Braidwood Commission on the Death of Robert Dziekanski in British Columbia.

The 2014 MacNeil Report recommended that standard operating procedures be drafted for communications personnel during the initial operational callout for serious events, but it did not make any equivalent recommendations about post-incident public communications. In 2016, a report of the Civilian Complaints and Review Commission for the RCMP evaluated the RCMP's public communications during its response to a 2013 flood in High River, Alberta. This review made the following findings:

- the RCMP had failed to integrate a strong public communications strategy into its emergency response;[28]
- insufficient communications professionals were made available, and they were inadequately incorporated into the overall response;[29]
- the ineffective public communications approach had a negative impact on the RCMP's emergency operation and reputation;[30] and
- the ineffectiveness of RCMP public communications during the response was a direct result of
    - inadequate policies, procedures, and plans relative to communications;
    - insufficient training on existing public communications policies and procedures;
    - poor planning;
    - under-resourcing of the communications function;
    - confusion about roles and responsibilities; and
    - lack of coordination of public communications internally and with partners.[31]

The Civilian Complaints and Review Commission recommended that the RCMP should "develop a national crisis communications handbook to identify the objectives, policies, and procedures to be followed during emergency operations."[32] It also made other recommendations with respect to resourcing the communications function, ensuring integration of communications and operations, and working with key agency partners on coordinated communications.

The commissioner of the RCMP, at that time Commr. Bob Paulson, accepted these findings and recommendations, but he stated that "a different vehicle had been

implemented" to make material that would be contained in a crisis communications handbook "available to members."[33] This "vehicle" is a national *Emergency Response Operations Guide*, which may be downloaded by members. A copy of this guide was produced to the Commission. It describes the function of communications during an emergency response and identifies some methods of public communications (such as via mainstream or social media, door-to-door canvassing, and "sirens and mobile public address systems").[34] As this list suggests, the guide is very high level and focuses on communications during an emergency operation. A section focused on communications identifies the need for accurate and coordinated communications and refers general duty members to the communications resources in their division. This guide certainly does not provide the comprehensive guidance for communications professionals that should be contained in a crisis communications handbook, and it does not respond to the findings of the Civilian Review and Complaints Commission in its report on the 2013 RCMP response in High River.

Two documents that were produced to our Commission referred to the existence of national RCMP standard operating procedures for crisis communications. We subpoenaed a copy of these procedures on June 13, 2022. In response, the RCMP provided a draft "RCMP Crisis Communications Reference Guide and Standard Operating Procedures." This draft is dated May 13, 2022, and was produced to us on June 30, 2022. We received no evidence that these draft standard operating procedures were in force or being followed during and immediately after the mass casualty, and we could not ascertain whether other national standard operating procedures existed at that time.

MAIN FINDING

RCMP communications personnel and leaders did not have effective standard operating procedures or policy to guide them in their public communications or to delineate the respective roles of national headquarters and divisional personnel after the mass casualty.

Inaccurate Information from the RCMP Following the Mass Casualty

RCMP witnesses acknowledged that there were problems with the transparency and accuracy of the RCMP's public communications[35] in the days following the mass casualty. While they testified that they never intentionally misled the public, some of the information they provided was incorrect and other information did not fully reflect what the RCMP knew at the time. We provide examples of inaccurate and incomplete statements in the final chapter of Volume 2, What Happened. Here, we review the evidence we heard about why these problems arose and how the RCMP sought to address them.

In the initial press conference at 6:00 pm Atlantic time on April 19, 2020, the RCMP told the public that "in excess of 10 people have been killed, but the investigation is still ongoing,"[36] and, "[I]t almost certainly will be more than 10, how much more than 10 I do not know."[37] When pressed by the media, C/Supt. Christopher (Chris) Leather said they could not state a definitive number because the investigation was ongoing across the province:

> [Canadian Press:] Canadians would very much like to know how many people have died?
>
> [C/Supt. Leather:] I can tell you that in excess of 10 people have been killed, but the investigation is still ongoing and I expect to have more details in that regard in the coming days.
>
> [Canadian Press:] Thank you very much and can you please explain what you mean by "in excess of"?
>
> [C/Supt. Leather:] I'm afraid at this time I can't expand on that any further.
>
> [Canadian Press:] You mean that you don't know?
>
> [C/Supt. Leather:] Correct. We don't have a complete, uh … we're not fully aware of what that total may be because as we're standing here the investigation continues into areas that we've not yet explored across the province.[38]

C/Supt. Leather also explained in this press conference that the burned properties posed a problem for RCMP investigators locating and identifying victims.

Notwithstanding the challenges presented by the perpetrator's arson, the RCMP knew by the time of this press briefing that the victim count was at least 17. Ms. Lia Scanlan, H Division's director of strategic communications, provided her recollection of how the number 10 was chosen:

> Any release of information has to go through the investigative team and ultimately – and especially in that early days, it had the input of others, including Supt. Darren Campbell and C/Supt. Leather. And so I don't recall the exact specifics as to why, but I remember there being good reason, operationally, or maybe – I know that some of the things that we were considering at that time is we were just uncovering new scenes. We had no idea – yeah. And another thing, like, with all – I hate to say this, the count went up and then it went down.
>
> ...
>
> Yeah, so what I can tell you is that when you're doing a press conference, you put a lid on it or you lock the notes down at a certain point in time when there's no threat to public safety, and you commit to a media strategy, and the media strategy is that you're going to give a press conference the next day and provide another update. And that's the decision that was made.[39]

C/Supt. Leather similarly explained in proceedings that his greatest concern was that he would overstate the number of casualties and cause offence or distress. However, he reflected, "by going to the number that I chose, it, in fact, ended up having the opposite effect."[40] He also stated that the number of casualties had been fluctuating, but he confirmed that he knew at the time of the press conference that it was greater than 10.

In Volume 2, What Happened, we explain that the RCMP did not conduct a systematic search for casualties in Portapique during the mass casualty. Despite receiving calls from concerned family members and friends starting at 10:00 am on April 19, no RCMP member checked the homes of the Oliver / Tucks and the Bonds on Cobequid Court until 4:45 pm on April 19. Ms. Scanlan's reference to the number of casualties going up may well have been a reference to the late discovery that Joy and Peter Bond, Jolene Oliver, Emily Tuck, and Aaron Tuck had been killed.

Her response also suggests that the RCMP did not, at that time, have a reliable list of confirmed casualties, even allowing for the challenges presented by the fires set by the perpetrator at the Gulenchyn, Thomas / Zahl, and Jenkins / McLeod homes. However, our record does not explain why the number went down – there is no evidence, for example, of calls to 911 about missing persons who later proved to be alive and well. There was, however, some confusion at times about whether the perpetrator's death was included in certain counts, and this point may be the source of that uncertainty.

Later in the evening on April 19, 2020, Commr. Lucki and her team told some media outlets that 17 individuals had been killed, although there was confusion about whether that number included the perpetrator. The Commissioner's release of updated victim counts raised concern among H Division staff, who had not planned to correct their earlier report until the next press conference, scheduled for the following afternoon. Ms. Scanlan wrote to her colleagues at national headquarters on April 19 expressing her frustration and asking that H Division be allowed to lead the release of information:

> Evening,
>
> Can I make a request that we stop changing numbers on victims. Please allow us to lead the release of information.
>
> It looks fragmented and inconsistent.
>
> The release of 10 was decided upon for good reason.
>
> I spoke with the CO tonight and we will be updating this tomorrow.
>
> We knew at the time of the press event that It was more than 10 but that is what we came to ground on for the event.
>
> That is our plan tomorrow, to update as our members continue their jobs and discover more crime scenes and bodies.
>
> The changes in number is causing our phones to ring off the hook and we are prepared tomorrow to provide updates where we can and victims are included in this update.
>
> For consideration
>
> Lia[41]

Mr. Daniel (Dan) Brien, director of media relations in the National Communications Services, indicated his agreement with this approach in a responding email. This exchange makes two things clear. First, the RCMP was aware when it gave the press conference at 6:00 pm on April 19 that it had understated the number of confirmed casualties. Second, coordination challenges between H Division and national headquarters about what information should be released, when, and by whom arose from the outset. The lack of clear guidance or standard operating procedures about roles and responsibilities between H Division and national headquarters contributed to these challenges. However, the email exchange also suggests that national headquarters had not contacted the team commander of the major crime investigation, later titled H Strong, before releasing this information. Neither Ms. Scanlan nor the national communications staff appear to have flagged this breach of national RCMP policy – their correspondence of April 19 is focused on media strategy and the respective roles of H Division and national headquarters. This conflict between H Division and national headquarters over control of public communications persisted and worsened in the aftermath of the mass casualty.

H Division shared an updated victim number with the public at the next press briefing, at 2:00 pm on April 20, 2020. At that time, they told the public that the RCMP was in a position to "confirm" that there were "in excess of 19 victims," "all of whom were adults,"[42] even though they knew there were potentially 22 victims. They also knew that one of the victims, Emily Tuck, was 17 years old. Acting Insp. Stephen (Steve) Halliday emailed two RCMP investigators after the press conference stating, "Just making sure this is accurate. I thought there was a 17 year old."[43] Sgt. Laura Seeley, a member of the Major Crime Unit, replied: "C/Supt. Leather is aware of all the victims and ages. He released what he felt comfortable confirming at the time. Thanks for following up though."[44]

C/Supt. Leather testified that he had misspoken when he stated that all the victims were adults. He explained that it was an error of recall on his part and not a deliberate misstatement. He reflected, "I regret to this day having said that."[45]

The RCMP also provided inaccurate information about the nature and timing of the initial 911 calls from Portapique. In the first press conference, H Division stated that the police responded to a "firearms call" on the night of April 18.[46] Subsequent statements published on Facebook and the RCMP website also described the initial 911 call as a "firearms complaint" received at "approximately 10:30 pm" on April 18.[47] As we explain in Chapter 3 of this volume, the first 911 call was placed at 10:01 pm by Jamie Blair, who advised that her husband, Greg Blair, had been shot by the

perpetrator and who, while she was on the call, was herself shot and killed. The RCMP's account of the initial 911 call was inaccurate as to the nature of the call and its timing. In testimony, C/Supt. Leather agreed that describing the initial call as a firearms call was "not the, in hindsight, the way we would have described obviously the events, and so it's not of the highest quality."[48]

The RCMP's description of its initial response to the critical incident also contained inaccuracies – for example, regarding a secure perimeter. C/Supt. Leather stated in the April 19 press conference: "Our focus was the safety of the residents in the immediate area. We secured the area and began a search for the suspect."[49] A similar statement was made in a statement posted online on April 22. In Chapter 2 of this volume, we explain that the RCMP's attempts to establish containment on April 18 were hindered by the lack of a scene commander and by miscommunications among the command group and between the risk manager and responding members. The perpetrator escaped Portapique via what local residents called the blueberry field road hours before effective containment was established east of Portapique. When asked about these statements, C/Supt. Leather confirmed he had not written them but "for me, it's almost a verb tense issue." He suggested it would have been better to say the RCMP initiated the process of securing the area or made efforts to secure the area, not that it was secured.[50]

Also in the statement posted online on April 22, the RCMP stated:

> [A]s soon as we learned that the suspect was possibly in a replica police cruiser and wearing what appeared to be an RCMP uniform, we immediately informed the public. Nova Scotians can rest assured that the RCMP is committed to keeping the public informed and instructing Nova Scotians on how to protect themselves from threats to public safety.[51]

C/Supt. Leather made a similar statement in the question and answer portion of the press conference held that same day. In Chapter 3 of this volume, we document that Ms. Blair described the perpetrator's vehicle as "decked and labelled RCMP" before 10:04 pm on April 18. We also analyze why almost three hours transpired between 7:30 am on April 19, when the command group received a photograph of the perpetrator's replica RCMP cruiser, and the time this information was publicly shared. In his testimony, C/Supt. Leather agreed that "immediately" was "probably not the best word to use" to describe the RCMP's public communications in this regard. He could not recall why that word had been chosen.[52]

A final important example of inaccurate statements being made during press conferences came on April 24, when Supt. Darren Campbell suggested that a victim had indicated to the first-responding members on scene "that there was one way in and out of the community. And it's important to note that." We found in Volume 2, What Happened, that the victim to whom Supt. Campbell was referring, Andrew MacDonald, did not make this statement. In fact, his wife, Kate MacDonald, told Cst. Victoria (Vicki) Colford at around 10:48 pm on April 18 that there was an alternative route out of Portapique, and Mr. MacDonald similarly described a back way out of the community in the interview that the RCMP conducted with him at 5:00 am on April 19. When asked about this statement, Supt. Campbell explained that it was based on information provided by Cpl. Gerard (Jerry) Rose-Berthiaume, who was then the primary investigator, and that it was important to note that information publicly because, "[a]s I understood at that time … the responding members believed that there was one way in and one way out of the community."[53] The information emphatically conveyed to the public on April 24 that this belief had arisen from incorrect information provided by a community member.

Counsel for the RCMP submitted:

> The RCMP made efforts in the immediate aftermath of the Mass Casualty to share information with the public. There was a good faith attempt to synthesize the details about what had happened and to provide accurate information to the public as quickly as possible.
>
> …
>
> With the benefit of hindsight, the most senior members of the RCMP have acknowledged that resources should have been brought in to assist the division respond to the call for more timely and detailed public communications in the wake of this tragedy.[54]

As we explain in the balance of this chapter, we agree that H Division required additional and more expert communications assistance in the aftermath of the mass casualty. However, we disagree with the suggestion from counsel for the RCMP that the need for these resources was driven by an external call for "more timely and detailed public communications."[55] It is true that after the mass casualty, the RCMP's public communications were neither timely nor sufficiently detailed, particularly with respect to information that was wholly within its control such as details about the critical incident response. To a certain extent, these problems

reflected the chaotic nature of the response itself and the extent to which H Division personnel were reeling in the days and weeks after the mass casualty. However, as past reviews have also emphasized, providing timely and accurate public communications is a core responsibility of the RCMP, and the organization should proactively resource and plan for it. Ramping up public communications on an ad hoc basis in response to media criticism is no substitute for such planning.

Furthermore, to a very large extent, the inaccuracies within the RCMP's public communications deflected attention away from errors in the RCMP's critical incident response: the failure to acknowledge and address that, despite their efforts to establish a perimeter, it was not secure, and the perpetrator had an alternative escape route; the failure to publicly share accurate and timely information about the nature of the initial 911 call, the threat presented by the perpetrator, and his replica RCMP cruiser; and the failure to locate, secure, and document crime scenes while the mass casualty was ongoing. In each instance, these inaccuracies made the RCMP response appear more organized, effective, and attentive to community safety than was, in fact, the case.

Notably, with the exception of public updates being provided about the number of casualties, the RCMP did not issue corrections or take other direct steps to correct the information it had provided to the media. While, in the short term, it may have seemed that omitting these details would serve the purpose of safeguarding public confidence, this approach quickly had the opposite effect. In the absence of clear policy direction or procedures that mandate the proactive sharing of accurate information with the public even where that information may not reflect well on the organization, the RCMP seems, perhaps without conscious intent, to have employed deflection and institutional self-protection.

The problems with the RCMP's public communications were widely noticed. Mark Furey, who was then the attorney general and minister of justice for Nova Scotia, advised the Commission that he expressed concerns about the RCMP's public communications to A/Commr. Lee Bergerman and to William (Bill) Blair, the federal minister of public safety and emergency preparedness. These conversations focused specifically on the "content and quality" of the early press conferences. Mr. Furey stated that he spoke with Mr. Blair "after each of the first four press conferences" and also after a press conference hosted by Supt. Campbell, and that he "encouraged" Mr. Blair to share "these observations in his discussions with the RCMP Commissioner."[56]

On April 22, Mr. Furey had a phone call with D/Commr. Brennan in which he expressed concerns about the lack of information provided about obvious questions in the first two press conferences. Mr. Furey also offered the RCMP access to provincial government briefing facilities, in light of technical difficulties they experienced with virtual briefings, but this offer was not taken up. Mr. Furey advised the Commission that, in his conversations, he was "[c]onscious of an ongoing investigation" and so "encouraged the release of as much information as possible, without compromising the ongoing investigation."[57] He explained that he was concerned because, as minister, "we want to exude confidence … [a]nd that clearly didn't happen."[58] While privately encouraging the RCMP to improve its public communications, the Nova Scotia government was also seeking to allay public concerns about the RCMP to allow investigators to do their work. On April 24, Premier Stephen McNeil "urg[ed] his mourning province to withhold their criticisms of the RCMP and try to help investigators unravel questions" around the mass casualty. On April 25, the first op-ed calling for a public inquiry into the RCMP's handling of the mass casualty was published by the Halifax *Chronicle Herald*. From that time forward, calls for a public inquiry grew more persistent.

H Division's Capacity to Manage Public Communications for a Major Event

Commr. Lucki testified that the problems with H Division's public and internal communications stemmed from a lack of capacity:

> I don't think it's the fault of any one individual or even the people on the ground. The Communications Unit in Nova Scotia is set up for day-to-day communications, but they're not set up for big events, such as what happened in this mass casualty. They didn't have the capacity, and so it was very difficult for them to keep the flow and the speed of the information coming forward. It was hard for them to be proactive in their communications because they didn't have time to look at things strategically.[59]

H Division personnel also emphasized that their communications resources were stretched thin after the mass casualty. Ms. Scanlan testified that she sought both short- and long-term relief, but it was not offered proactively: "[T]hat was initiated by me."[60] She explained that an experienced communications professional came from British Columbia to Nova Scotia in late May 2020 (over a month after the mass casualty) to implement a relief structure, and "[t]hat was the first time I exhaled."[61]

On April 25, 2020, Ms. Scanlan wrote to her counterparts in Ottawa with concerns about her team's capacity to manage demands related to strategic communications, issues management, and internal RCMP communications. The email is titled "The go forward" and states:

> I have no questions, I have a comment though – Thank you :) For the continued support. You have been outstanding and answer emails, phone calls at all hours and are willing to do anything. Now that it's Saturday I think we have to step back and think of how to proceed. …
>
> As you know we are a small crew, but a mighty one ;) … Ottawa is providing support off site but we need bodies here embedded with us and to relieve us as the weeks go on. Tomorrow is day 7.[62]

This email referred to the challenges of "[m]aintaining strong internal [c]ommunication" and identified in particular the pressure of seeking to "lift up and support" RCMP members "while being mindful of facts," including concerns that were by then being expressed in the media.[63] Ms. Scanlan pointed to the need for media monitoring "so that issues or areas where we can provide insight / clarity are identified" and spokespersons can be properly briefed.[64] She identified that the H Division communications team "has no capacity or time to watch the news" and that wellness concerns also arose with respect to exposing H Division staff to the news.[65] She also acknowledged that national headquarters had supplied some support with respect to the RCMP's website. Ms. Scanlan forwarded this email to H Division command, including A/Commr. Bergerman, C/Supt. Leather, and Supt. Campbell.[66]

Commr. Lucki acknowledged during her testimony that it took national headquarters too long to provide additional resources to the H Division communications unit:

> In normal circumstances, we would have sent those people down there immediately. But given the restrictions we only brought down operational personnel in the first instance because we were afraid that we might bring COVID to Nova Scotia …
>
> I look at it now, and I go, you know what if this was – if I was to do this differently, I would have – I think the importance of communications, it's different than the operational response, but the Communications is as important. Because it's one thing for something to happen, but if you can't communicate it, the families deserve no less, the people in Nova Scotia deserve no less. Canadians want to know what was happening. This was an, and I hate using the word, unprecedented event, and so we needed to be better at our communications.
>
> They just didn't have the capacity, and we didn't provide them … So if something big like this happens, they may not have the capacity, but we need to assist them and provide them with the capacity, and we didn't do that.[67]

The failure on the part of RCMP national headquarters to provide H Division with necessary support and resources was not only a failure to provide communications staff with relief at a time when, in Commr. Lucki's words, "literally their comms unit was working 24/7."[68] It was also a failure to recognize, as Ms. Scanlan signalled in her email of April 25, that H Division personnel were deeply and personally affected by the mass casualty. The failures in RCMP public communications had complex drivers, which were partly a product of H Division personnel wanting to be supportive of colleagues who were grieving even as their work was being roundly criticized in the media. Aware of their obligation to be "mindful of facts" in their dealings with media, they were simultaneously coming to terms themselves with the scale of the mass casualty and with the lives taken during that incident, including the murder of a well-loved colleague. The RCMP's executive leadership should have recognized immediately that the situation cried out for relief staffing, but relief was slow in coming.

Concerns About RCMP Communications in the Early Post–Incident Period

H Division's initial press briefings prompted concern and discussion at RCMP national headquarters. D/Commr. Brennan acknowledged in his interview with the Commission that "it wouldn't come as a surprise to anybody that, you know, the first few press conferences or media releases didn't go as smoothly as we would have hoped, probably left a lot of questions unanswered."[69] Commr. Lucki also acknowledged in her testimony that national headquarters observed serious problems with H Division's public communications after the mass casualty. She explained that national headquarters staff tried to push H Division to be more transparent and strategic in their communications:

> [They] were really pushing the envelope with the communications people to be as forthright and be more proactive than reactive. Because the narrative, as was – as we spoke about before, was changing negatively towards the – towards the event and towards the RCMP, and my Strategic Communications was looking at that and trying to figure out how we could best address that and counter that.[70]

D/Commr. Brennan similarly described ongoing discussions between national headquarters communications staff and their counterparts in H Division about the need to proactively share information:

> [T]here was a great deal of back and forth conversations between National Comms, Communications, and the Divisional Comms about information being put out, timelines … timelines, etc., and that we really needed to ensure that we were providing information because one of the goals of the Comms, especially in this one, was we needed to bring a sense of calm to the Province and to the citizens, just to say, "Yes, unimaginable tragedy, but we are working our way through this and that there's no further threat," or, "These are … these are the … the next steps that we are taking." So, again, balanced against what we're able to say in terms of not jeopardizing any ongoing potential operations, and that our answers needed to be, you know, well thought out because some of the

> questions were obvious … And we felt that we could be doing a better job getting ahead of that and sort of telling our story, when appropriate and where possible.[71]

On April 22, Commr. Lucki indicated in a meeting with D/Commr. Brennan and national headquarters communication staff that she wanted the RCMP to produce a timeline of the mass casualty as soon as possible and to identify a consistent media spokesperson. D/Commr. Brennan confirmed these expectations with Ms. Sharon Tessier, the director general of national communication services, on April 23. Also mentioned in this meeting was the "need to have answers and statements related to the weapons used, possessed, seized, etc." and the need to prepare Commr. Lucki for media appearances on Friday, April 24.[72] D/Commr. Brennan spoke to A/Commr. Bergerman to relay the directions to provide a timeline and answers to "obvious questions as they are being answered on social media."[73] He told her that H Division needed to "address questions related to weapons, Firearms Acquisition Certificate, etc." and ensure that operations personnel were properly briefing the Communications Unit.[74]

Mr. Rob O'Reilly, Commr. Lucki's then chief of staff, explained in an interview with the Commission that "the Commissioner's preoccupation throughout that entire week was on the clarity of information being provided publicly, the deconfliction of information, wanting to make sure that we were as kind of forward leaning as we could [be]."[75] Supt. Constantine (Costa) Dimopoulos, who was seconded to H Division to lead the Issues Management Team in the aftermath of the mass casualty, explained the RCMP usage of the term "deconfliction" in an interview with the Commission. He described it as a process of ensuring that everyone who has a stake in an issue is "on the same page" and providing consistent information to third parties.[76] Mr. O'Reilly recalled that the RCMP was "getting hammered, for lack of a better word, in the … media over … our public-facing management of this … of the situation."[77] He explained that, even when the RCMP is unable to provide certain information, Commr. Lucki emphasizes the need to demonstrate an attitude of openness with respect to public communications:

> [T]he Commissioner has always kind of emphasized a real kind of abhorrence of … of the general attitude of no comment… always challenging that concept of saying instead of instinctively going to that, why, why are you saying that? Do we truly need to say no comment? Can we be more … more forthright?[78]

During her testimony, Commr. Lucki affirmed this approach:

> [S]ometimes we automatically assume we can't release any information because something's under investigation, but I think sometimes we have to flush through it and think about, is it an absolute or is there things that may or may not be able to be released that wouldn't compromise it to provide that information to the public … Because we've seen it done in other police agencies across Canada where something goes on, and they're – they seem to be able to talk more about things and for some reason in the RCMP we're very guarded about our communications under the umbrella of an investigation.[79]

Mr. O'Reilly also described difficulties with respect to obtaining information from H Division to brief the commissioner properly in the days after the mass casualty:

> [W]anting to try herself as Commissioner of the RCMP to get as much information as we … we can. As you can appreciate, in any situation, there is a push and pull of information, and in a perfect world, things are being pushed to us and we're not having to try and pull it. There would certainly have been a conscious notion on my part to not want to reach into the division, to not bother them, recognizing that I would just be a fly in the ointment and that wasn't going to be helpful in any respects; but at the same time, wanting the Commissioner to have as much information as she … she can because she's getting asked questions. She's getting asked questions by the media constantly and by the Minister of Public Safety.[80]

In sum, by April 25 there was an internal consensus on the part of RCMP national leadership and communications staff that more information could and should be shared externally. By this same date, H Division had requested additional resources to enable it to be more responsive and better prepared for public briefings. Ms. Scanlan had also signalled that H Division was finding it difficult to provide adequate internal briefings and asked for more resources to assist with this responsibility. Commr. Lucki was experiencing the effects of these challenges: **"Normally in an event like this there would be two to three briefing notes or situational reports per day. I think I received maybe three in 8 or 10 days. So the flow of communication wasn't at the normal pace that is usual for an event such as this or for any major event."**[81]

The media conversation was growing increasingly critical of the RCMP, and media outlets were at times releasing information in advance of the RCMP. Both Mr. Blair and Mr. Furey were expressing concerns to RCMP executive leadership about the content and quality of the RCMP's public communications. These strained circumstances provide the context for the RCMP teleconference on April 28, 2020, between senior staff in national headquarters and H Division.

The April 28, 2020, Meeting

Commr. Lucki's frustrations with communications about the mass casualty came to a head on the evening of April 28, 2020. Earlier that day, Supt. Campbell had acted as RCMP spokesperson in a press conference. He provided an update on the investigation, identifying that the RCMP's priorities were "to determine how the gunman obtained access to the equipment that he used, and to establish the gunman's movements before and after April 18th and 19th [*sic*]. We also want to determine," he said, "if anyone had knowledge of the gunman's plan, if any, and if they assisted him in any way."[82] He shared information about the scale of the investigation, the perpetrator's access to items of the RCMP uniform, the replica RCMP cruiser, and what was then understood about the perpetrator's activities during the mass casualty. He also issued a plea for members of the public to come forward if they had any information. Finally, he clarified a remark he had made on April 24 in which he characterized the perpetrator's assault on Lisa Banfield as the "catalyst" for the mass casualty.[83] In the question and answer period, he was asked by a journalist about the firearms the perpetrator used during the mass casualty. He responded:

> I can't get into the details about those weapons outside of the fact that, as I stated on Friday, that the gunman was in possession of several semi-automatic handguns and two semi-automatic rifles. In terms of the calibre of those, I can't get into those details because the investigation is still active and ongoing.[84]

In response to a follow-up question from a representative of the National Firearms Association, Supt. Campbell confirmed that the perpetrator had a weapon that could be described as a "military style assault weapon" but that the RCMP was

withholding further details for investigative purposes.[85] Specifically, Supt. Campbell explained that details about the perpetrator's weapons were being held back so that the RCMP could assess the credibility and weight of information shared by witnesses. As this press conference shows, by April 28, media and interest groups were focusing on questions about the perpetrator's firearms, and the RCMP was being pressed to provide more information.

Commr. Lucki explained that the information she shared with Mr. Blair about the perpetrator's weapons responded to "a grocery list" of questions he asked which, "as they got the information, obviously the list got smaller."[86] By April 22, the only items remaining on that list were the perpetrator's weapons, a "chronology of the event and where things happened and how they happened," and information about the perpetrator's background. On April 23, Commr. Lucki provided Mr. Blair's chief of staff with a list of firearms found in the stolen vehicle in which the perpetrator was killed. The list included details such as make, model, calibre, action, and what was then known about the source of each weapon. Commr. Lucki requested that this information not be shared with anyone other than Mr. Blair and Prime Minister Trudeau "as it is directly related to this active investigation."[87] She explained to the Commission that she wanted the RCMP to release details about the perpetrator's firearms to the media, "because the media was asking often about the guns," and to avoid the situation in which information (real or speculative) was shared by others – "and then we were on our heels trying to react to it."[88]

By late in the week of April 20, the RCMP was preparing for the press conference that occurred on April 28. Commr. Lucki said Mr. Blair's chief of staff asked on April 27 "if the media event would include the details of the guns."[89] She asked Ms. Tessier whether the weapons would be included and received an affirmative response. As soon as Commr. Lucki got this confirmation, she advised Mr. Blair's chief of staff that the information would be included.

It later emerged that Ms. Tessier or another member of the National Communications Unit had misunderstood what they had been told by H Division and that miscommunication had ensued. As Ms. Tessier explained to Commr. Lucki after the press conference:

> I went back and asked, "Are we – is [Supt.] Darren [Campbell] gonna speak to this?" And I was told, "Yes, he's putting it in himself. He's gonna speak to it, but they don't want it in the speaking notes because they don't want it posted." I can't even remember who told me that … it's not

> even relevant probably … I took that and then when I went back to ask and [national director of media relations, issues management and social media] Dan [Brien] "Is he going to be speaking about that?" What Dan told me, but of course, because of course this is just like, the biggest cluster ever, Dan said to me after, "Well no, I didn't mean he was putting them in his notes, I meant he was putting them in his questions." So, it all got bunged up … I take full responsibility for telling you they were in his notes. That was my understanding.[90]

Also on April 27, D/Commr. Brennan called an H Division communications staff member to ask whether the RCMP could be specific about the guns seized, including calibre. On April 28, before the press conference, Ms. Scanlan advised D/Commr. Brennan by email:

> Superintendent Campbell intends to confirm semi automatic handguns and what can be considered as assault weapons. He and the investigative team believe people may have information about the guns. No other guns seized than what was in the vehicle. This is what he is comfortable saying.[91]

D/Commr. Brennan did not convey this information to Commr. Lucki before the press conference took place. Nor did he advise her that he had received this information in advance when Commr. Lucki requested a meeting with A/Commr. Bergerman "and her team down there about this press conference."[92] D/Commr. Brennan told the Commission that he agreed with Commr. Lucki that "we needed to address the issue of communications."However, he suggested to Commr. Lucki that the evening of April 28 "wasn't the opportune time" for a meeting about her concerns about communications issues.[93] Commr. Lucki pressed her request that a meeting be convened "immediately" and the teleconference began about 15 minutes after her conversation with D/Commr. Brennan.[94]

Commr. Lucki told the Commission that she pressed for this meeting because "all the frustration that I was feeling with the communications up to that point, there was a ton of things that were not going right in the communications, and it was just a buildup of frustration at that point … I wanted to have a meeting because I wanted to outline my expectations. I wanted to outline where I felt that things weren't going well."[95] She reflected, "I probably should have waited 24 hours because it was just for me, it was kind of like the straw that broke the camel's back on just a number of communications issues and then, yet another one."[96]

The teleconference was attended by the commissioner, Mr. O'Reilly, D/Commr. Brennan, national headquarters communications staff Ms. Tessier and Mr. Brien, as well as four senior H Division personnel: A/Commr. Bergerman, C/Supt. Leather, Supt. Campbell, and Ms. Scanlan. This meeting led to severe strain between national headquarters and H Division and later gave rise to allegations of political interference in the RCMP's investigation. On October 17, 2022, the Commission received three audio files containing a partial recording of the meeting. On October 21, we received an affidavit that detailed the steps taken by the RCMP to obtain these files. The recordings were captured by Mr. Brien, although how and why he made these recordings is unclear.

During the meeting, Commr. Lucki expressed frustration and disappointment related to public communications and to the flow of information from H Division to national headquarters about the mass casualty:

> I was very frustrated, very disappointed and I was feeling quite disrespected by what happened today and probably some of the stuff that's happened this week. The flow of information has been very difficult and I respect the Command Triangle. I respect the protocol around keeping certain information back so that you keep the integrity of the witnesses. I've been there.[97]

She also acknowledged: "I know that everybody is working their hardest to do the best they can … I accept that and I've been defending it all week."[98]

Commr. Lucki said that H Division had not provided adequate briefings to the commissioner's office and, on multiple occasions, had not provided information to national headquarters when requested. In turn, she had been unable to produce information to the minister of public safety and emergency preparedness and the prime minister, including a map and timeline of the mass casualty. The commissioner said that the RCMP's inability to deliver this information promptly reflected poorly on the organization:

> I have apologized to the Minister; I'm waiting for the Prime Minister to call me so I can apologize and I'm telling you it's not about me. I could care less that I have to apologize for dropping the ball, it's about the reflection of our organization, and it's about a reflection that makes it look like we don't know what we're doing.[99]

She also emphasized that when the RCMP is not forthcoming with information, the public will look to other sources for answers:

> I know people are working as hard as they can, but we have a responsibility, and every time we've dropped the ball on give – providing information, you know who's filled the ball, filled that gap? The media's filled the gap. Retired Members who haven't been in the field for 10, 15, 20 years are filling that gap. Why? Because we – we are not filling that gap.[100]

Commr. Lucki specifically addressed the fact that information about the perpetrator's firearms had not been included in the press conference that day. She stated that she had received a request from the minister's office, "and I shared with the Minister that in fact it was going to be in the news release, and it wasn't."[101] She had understood this information would be included in Supt. Campbell's prepared remarks, but instead it was shared "by fluke," in response to a question from a journalist.[102] Ms. Scanlan said that she had advised D/Commr. Brennan more than two hours before the press conference what information Supt. Campbell and the command triangle were comfortable sharing. Mr. Brien confirmed "there was never any understanding that we would be actually changing his remarks, because those were pretty much a lock," and so they changed the prepared answer to a likely question about firearms.[103] In response to this explanation, Commr. Lucki said:

> Does anybody realize what's going on in the world of handguns and guns right now? The fact that they're in the middle of trying to get a legislation going, the fact that that legislation is supposed to actually help police and the fact that the very little information I asked to be put in speaking notes at around 11:30 this morning … could not be accommodated.[104]

This was the only reference to firearms legislation captured in the audio recording of the meeting that was produced to us.

Supt. Campbell responded that he "wasn't given any kind of updated insertion on the weapons, so that never even made it into the notes" of his prepared remarks.[105] At that point, Commr. Lucki alluded to the delay in obtaining a detailed map and chronology, to which A/Commr. Bergerman observed "that's not because we're all sitting here doing nothing … we worked really hard to meet the deadline and couldn't meet it with the information that was coming in."[106]

Commr. Lucki asked "how did it get to me that … the one line that I needed to be put into Darren's speaking notes; how did it get to me that that one line was going to be in his speaking notes, and it wasn't?"[107] Ms. Tessier explained that she had misinformed the commissioner about H Division's plans in this regard, based on a misunderstanding on her part.[108] Commr. Lucki observed:

> [T]o watch what happened last week, to watch the media chew us up, eat us up and spit us out, and to watch what, or to hear what the Minister and the Prime Minister had to say about the RCMP's inability to communication, I will never forget it, because I know we're better than that.[109]

Toward the end of the recorded portion of the meeting, Commr. Lucki asked a number of questions about additional resources being offered to H Division communications and about the flow of information between the investigative command triangle and communications. She expressed frustration at H Division's failure to accept the assistance that had been offered: "[I]t's interesting because, you know we offered up, communication assistance on Sunday, we offered it up on Monday, we offered it up on Tuesday and none of it was um, 'Nope, we got this. We got this.'"[110] It is apparent from these questions that Commr. Lucki had not seen Ms. Scanlan's email of April 25. Ms. Scanlan explained that she had been "quite specific" in her requests for support.[111] When Commr. Lucki followed up to suggest that support had been offered and rejected, Ms. Scanlan responded: "[T]he email that I sent on Saturday … I thought it was pretty thorough, pretty clear."[112] At this point, the recording ends.

By all accounts, it was a tense meeting. It became evident during the meeting, and is even more apparent from the Commission's evidence-gathering process, that the problems Commr. Lucki was experiencing with internal briefing and ensuring that her expectations were understood by RCMP staff in Nova Scotia arose from failures in internal communication and coordination in the chain of command that lay between Commr. Lucki and Ms. Scanlan. Ms. Scanlan had requested – and not yet received – additional support resources; she had conveyed the decision not to include details about the perpetrator's firearms in the press conference to D/Commr. Brennan and could reasonably have expected that this information would be conveyed to Commr. Lucki. In turn, Commr. Lucki had acted on wrong information that was inadvertantly given by national headquarters communication staff and not by H Division personnel. **What is most apparent to us from the recorded portions of the April 28 meeting is that there was indeed a**

communications breakdown arising between Commr. Lucki and the H Division personnel who were working directly on the aftermath of the mass casualty.

The motivation behind Commr. Lucki's desire to publicly release information about the perpetrator's firearms attracted significant attention during the Commission's process. Some RCMP witnesses and Participants expressed concern about whether there had been an attempt to interfere with the integrity of H Division's investigation, and specifically whether there had been attempted political interference. Other Participants submitted that attempted political interference is not established on the Commission's record. Commr. Lucki categorically denied that she received any direction or instruction to publicly disclose information about the perpetrator's firearms or that there had been any other form of interference or attempt to interfere with the RCMP's investigation. In June 2022, the Parliamentary Standing Committee on Public Safety and National Security (SECU) initiated proceedings to investigate allegations of political interference related to the April 28 meeting. We return to the governance relationship between the minister of public safety and emergency preparedness and the commissioner of the RCMP in Part C of this volume and supply a longer discussion of the tensions between police operational responsibility and democratic oversight of policing in that context.

One Participant counsel suggested to Commr. Lucki that "there are those that would be concerned that the optics" of introducing gun control legislation on May 1, 2020, "are that the collective grief and pain of my clients and others was being exploited … to affect the crass political objectives of legislatures."[113] In Volume 4, Community, we discuss the practice of strengthening gun control legislation after a mass casualty incident. In particular, we identify that this is a common legislative response to mass casualties, and a step that has been taken by governments of all political stripes. For example, a conservative government strengthened gun control legislation in Australia in the immediate aftermath of the Port Arthur Massacre in Tasmania in 1996.[114] Police agencies, including the RCMP, also have a legitimate interest in legislation – such as firearms legislation – that affects policing and community safety. The common practice of inviting police spokespersons to comment on such legislation in parliamentary committees acknowledges this interest. Commr. Lucki's audio recorded remarks about the benefits to police of proposed firearms legislation were ill-timed and poorly expressed, but they were not partisan or indicative of any attempted political interference.

Aftermath of the April 28 Meeting

The April 28 meeting reflected and contributed to the deterioration of the relationship between H Division and RCMP national headquarters after the mass casualty. In this section, we examine the immediate and continuing impact of the meeting on H Division personnel, before addressing the damage resulting from the failure to brief Commr. Lucki about the serious fallout from this meeting.

Impact of the April 28 Meeting on H Division Personnel

All witnesses acknowledged that the April 28 teleconference was a difficult meeting. While it does not appear that Commr. Lucki raised her voice, she expressed her disappointment and frustration with H Division's performance with respect to public communications and internal briefing. She was clear that H Division was not meeting her expectations in these areas. It is apparent from the audio recordings that she was not aware of efforts H Division staff had made to brief upward and address the challenges they had experienced – in particular their efforts to secure more assistance at a time when they were working around the clock. Commr. Lucki's criticisms caught the H Division employees off-guard.

A/Commr. Bergerman described her reaction to the meeting as "stunned"[115] – essentially because she felt the way the meeting progressed was inappropriate:

> [Y]ou had Chief Superintendent Darren Campbell left the meeting upset and you had Lia Scanlan who was crying. And you have to remember these people, we all have been working, you know, 20 hours a day. Darren Campbell, I don't think slept for three or four days before this press conference because he knew the importance of it. So, for me, this conversation and the way that they were treated was inappropriate.[116]

Supt. Campbell said he was "floored" by the commissioner's remarks and did not understand where her disappointment was coming from.[117] He explained that while the commissioner did not say so directly, he interpreted her comments about impending gun control legislation to imply that he was not smart enough to understand the bigger context surrounding the release of information related to the perpetrator's firearms. He felt belittled by these remarks. Both Supt. Campbell

and Ms. Scanlan became so upset that they left the meeting before it was over. Ms. Scanlan was visibly emotional. Supt. Campbell said he felt "sad and disappointed" and that it was a "memorable day" for him.[118] C/Supt. Leather told the Commission that the commissioner's tone and comments during the meeting were out of character for her, and he felt they were demeaning. His chief concern was for Supt. Campbell and Ms. Scanlan, who appeared to be significantly emotionally affected by the meeting. He described Supt. Campbell as being hurt "to his core":

> [Supt. Campbell] used to be the Corps Sergeant Major and worked closely with the previous Commissioner [Commr. Paulson] and is a true RCMP member as you'll ever find. So, it really hurt him to his core. The Corps Sergeant Major is a symbolic position, but only members who, you know, bleed RCMP red get selected for those positions. So, it was very disheartening for him.[119]

Commr. Lucki acknowledged that while it was necessary to communicate with H Division that they were not meeting her expectations, she should have held the meeting on a different day:

> I knew it wasn't going to be a nice conversation to have because I was telling them that they weren't meeting my expectations, so of course, that's not a … a good conversation to have, but it was a necessary conversation. Was it necessary that day? Probably not.[120]

She also testified that she could have delivered her message more sensitively to the H Division employees:

> I could have been more sensitive. I look at – I look at it from a leadership point of view. I forget, first of all, the – the power of the Commissioner's office. Sometimes I even forget I'm the Commissioner, honestly, because I know – I like to connect with people. I could have been more sensitive. I could have tempered my comments with more positiveness. There's a few things. But I was truly frustrated. I was hurt that the negative narrative on my people watching it happen when I knew they did the best they could during – with the circumstances they faced and watching that happen before my eyes and feeling completely powerless, it was difficult. It was difficult as a leader. And I ought to have maybe just waited 24 hours. Maybe I should have only talked to the Commanding Officer … So that's

> why, when I replay that meeting and I think of the things that I could have done better as a leader, I know that I still needed to outline the problems and I still needed to outline my expectations, but I could have done it differently. And that's the thing that keeps me up at night.[121]

Commissioner Not Briefed on the Fallout from the Meeting

After the meeting, A/Commr. Bergerman called D/Commr. Brennan and told him that she did not think the commissioner appreciated the negative impact of the meeting on H Division employees. She also raised the issue of senior executives circumventing the chain of command:

> I was angry at the way that … I was disappointed at the way that my employees were treated, and I told Deputy that I was confused, like, why are people going directly to … you know, him going directly to Comms people asking for information and it really should be going through me or at the very least, [C/Supt.] Chris [Leather]. And, um, and I told the Deputy that I don't think she [Commr. Lucki] understands the negative impact that that conversation and that meeting had on her and on my employees.[122]

A/Commr. Bergerman, who reported to D/Commr. Brennan, expected him to brief Commr. Lucki regarding her concerns:

> I don't know if … if the Deputy would have briefed her on my conversation, but that would be my expectation, that's why I phoned him. Because he didn't … I don't think he understood because, of course, he wasn't in the room with me, so, he's not seeing the Superintendent walking out and he's also not seeing Lia crying, so, I wanted to make sure he knew that, and I would expect he would have passed that on.[123]

D/Commr. Brennan did not, however, share A/Commr. Bergerman's concerns with Commr. Lucki. He testified that he did not provide this information to the commissioner because he had not appreciated the severity of the impact on the H Division

employees and that he would have "been a lot more forward leaning with the Commissioner" if he had understood this impact.[124] He reflected:

> [I]t was a judgment call at the time. And as I said in my interview, I didn't have an appreciation at the time for how deeply affected individuals were in regards to that phone call. [A/Commr.] Lee [Bergerman] did express people were very disappointed in the call and, you know, that the timing of it was improper, that the Commissioner, in their opinion, the Commissioner wasn't, I guess, sensitive to all the work and the efforts and the stress that people were under.
>
> And it was one of those unfortunate things where when you cannot see the people that you're interacting with, you can't read the body language, you can't see how upset people are. And unfortunately, you know, at senior levels, not just in policing, but in organizations, sometimes difficult conversations are had. People react differently to it. And I was – I took – I just took the position that this was something that obviously, people were upset, but that we needed to work our way through this in terms of the goals and objectives. And I've been in meetings where, you know, I'm not happy with the way the meeting went, but you tend to work your way through it. And as I said, in hindsight, if I had of known immediately how deeply affected people were, I would have definitely briefed the Commissioner by letting her know how that really, truly affected people. And it wasn't until much later on, I believe it was almost a year later from the events of April 18th, that one of the [meeting] participants wrote a letter to the – or message to the Commissioner, and that's really at the time when it hit, especially me, how that meeting had gone and how deeply it affected people so.[125]

D/Commr. Brennan agreed that with the benefit of hindsight, he should have briefed Commr. Lucki so that she had an opportunity to address the concerns about that meeting.

Commr. Lucki did not learn that H Division personnel had such strong reactions to the April 28 meeting until about a year later when she received a letter from Ms. Scanlan. She said she wished she had known earlier and, had she understood the impact of the meeting on her employees, she would have immediately tried to "make things right."[126] Unaware of the impact of the April 28 meeting on H Division leadership, the commissioner did not take timely action to address staff concerns

and the associated effects on morale and well-being. As we examine in the section below, the damage from this meeting did not resolve with time but contributed to dysfunctional levels of mistrust of RCMP national headquarters among H Division senior staff. As we also explain, this occasion was not the only one on which the commissioner was not briefed about information regarding the well-being and morale of H Division leadership. This concern arose again in relation to the Quintet wellness report.

Role of April 28 Meeting in Deteriorating Leadership Relation

The fallout from the April 28 meeting is connected to a broader issue: a deteriorating relationship between H Division leadership and national headquarters in the aftermath of the mass casualty. The anger and disappointment of H Division personnel who attended the meeting did not resolve with time. Nearly a year after the April 28 meeting, Ms. Scanlan wrote to Commr. Lucki describing the impact of that meeting and her extremely difficult experience with her work on the mass casualty and its aftermath. In July 2021, senior H Division personnel continued to raise concerns about the April 28, 2020, meeting. At that time, July 2021, 24 H Division commissioned officers and their civilian counterparts were interviewed by the Quintet Consulting as part of a wellness assessment.

The Quintet Report, *Wellness Assessment*, indicates that the April 28 meeting and associated conflict with national headquarters over communications continued to be a topic of concern among both H Division personnel who attended the meeting and those who did not. The report says that H Division leaders felt that national headquarters "did not appreciate the size or gravity of the issues and the need for support at higher levels."[127] It identifies that concerns about political influence in national headquarter's approach were widely held among H Division personnel:

> There was a widespread belief among participants that NHQ [national headquarters] was more interested in satisfying political questions in Ottawa rather than dealing with an unfolding operation of "gigantic proportions" that would affect the Province, the RCMP, and individual Members and civilians for years to come.[128]

Commr. Lucki's comments with respect to firearms legislation were mentioned by H Division personnel as evidence that supported this belief. Her acknowledgment that systemic racism exists in the RCMP was also cited as an example of a "politically motivated" statement that "threw us all under the bus."[129]

The report identifies the ramifications of this mistrust on morale and well-being in H Division:

> Several participants stated that fractured communications with NHQ [national headquarters] in the wake of the MCE [mass casualty] contributed to an ongoing loss of trust and deep sense of isolation. Typical comments were "never felt so undervalued," "it was shameful and disgusting," "Ottawa did not care … The Minister did not care," "We felt alone," and "it was a merry-go-round to hell which is leading to burnout."[130]

We return to the Quintet Report in Part C of this volume, where we address the RCMP's culture in more general terms. For present purposes, we note that while we place no reliance on the accuracy of these untested allegations, the fact that they were made demonstrates that more than a year after the meeting of April 28, 2020, that meeting continued to have corrosive effects on H Division leadership. The Quintet Report was completed on September 30, 2021, and was provided to Gail Johnson, the RCMP's chief human resources officer, and to D/Commr. Brennan in October. However, Commr. Lucki was not told that the report had been completed, and she did not receive a copy until she requested one in the spring or early summer of 2022. When asked why Commr. Lucki had not received a copy sooner, D/Commr. Brennan testified that he assumed the chief human resources officer had engaged with Commr. Lucki about the report and he did not think it was his responsibility to do so. The report was not shared with H Division leadership, and they received no information about its findings until an action plan for implementing the report's recommendations was provided to them by email in July 2022.

Continuing Internal Conflict Over Public Communications

The April 28, 2020, meeting is the most prominent of several examples of conflict between national headquarters and H Division personnel in relation to the RCMP's post-incident public communications strategy. RCMP personnel at national

headquarters were frustrated by what they perceived to be H Division's failure to be proactive in providing information to the public after the mass casualty. Commr. Lucki referred several times to attempts by national headquarters to push H Division to be more forthcoming with information. However, H Division leaders perceived things differently. At times, they told us, they felt constrained by national headquarters from proactively addressing certain issues in the media.[131] Supt. Dimopoulos described this constraint in an interview with the Commission:

> I recall specifically writing to A/Commr. [Dennis] Daley, writing an email to him, specifically saying, look, we … we need to start going out with information and with an appropriate response to some of these issues, because we're not saying anything. And by not saying anything, all we're doing is contributing to a media frenzy and a false narrative and a distraction to the investigation. Because every time, for example, a media request would come in, we would have to divert resources to, you know, to … to mine information and go out with something. And I was the firm … I was a firm believer as well as others in that unit, in that Issues Management Team, that we could have proactively gone out through Comms on a bunch of these issues and instead a different approach was taken, especially through … through National Headquarters, and … and when I wrote … when I wrote Dennis Daley that message and I have the date, I believe it was on May 19, I … I sent him an email specifically saying, you know, "We need to get out and start communicating." And his response back was, you know, that the Commissioner had mentioned this at the roundtable, her roundtable in national headquarters and his response was, simply put, that they were looking for a strategy, but in the end, the strategy may be that there was no response at all, which, you know, in my mind, is not much of a strategy. Saying nothing is … is not a strategy. And I was a little, you know, a little taken aback by that posture. I don't think it was necessary to … to have adopted a posture like that, especially when some of the issues that were … we were being asked to deal with in the Communications department, like specifically under Lia Scanlan, were simple to … to deal with, had we had the right support and the right resources to deal with that stuff.[132]

Conflict arose again over the RCMP's proposed participation in a documentary about the mass casualty by the CBC's *Fifth Estate* in June 2020. Staff from the *Fifth Estate* contacted Nova Scotia RCMP and asked them to provide an interview

for the program. Ms. Scanlan consulted with Supt. Campbell, who was willing to do the interview and was supportive of the RCMP's participation. Ms. Scanlan recommended to A/Commr. Bergerman that H Division proceed with the interview, and, as commanding officer in the province, she supported the proposal. However, Commr. Lucki, in consultation with D/Commr. Brennan and her management team, ultimately decided to cancel the RCMP's participation in the program. A/Commr. Bergerman said she discussed national headquarters' decision on the matter with D/Commr. Brennan, but "it wasn't up for debate."[133]

Commr. Lucki explained that several factors played into the decision not to participate but that the primary reason was a concern about potential interference with the Mass Casualty Commission and *Canada Labour Code* investigations. She referred to the need to protect the integrity of these processes. However, it appears from her evidence that the decision had more to do with concern about public perception than a risk of actual interference with the Commission's work:

> PARTICIPANT COUNSEL: Your testimony is that really it was out of an effort to protect the Mass Casualty Commission and the integrity of that process?
>
> COMMR. BRENDA LUCKI: Well I think the timing was just not the right timing because we were right in the midst of announcing, imminently, a Mass Casualty Commission.
>
> PARTICIPANT COUNSEL: Right.
>
> COMMR. BRENDA LUCKI: And to run out in front of the media, just prior to announcing a Mass Casualty Commission, may look that – you know, it may look like self-serving, almost. And so there's risk to doing something and there's risk to not doing something. And it's – you know, you're darned if you do and you're darned if you don't sometimes. And sometimes people are going to criticize you no matter what decision you make. So I think there would have been more criticism if we ran out in front of the media and did a fulsome interview on all of the facts associated with this mass casualty just prior to a commission being announced.[134]

Commr. Lucki testified that the responsibility to explain the decision to H Division leadership would have fallen to either D/Commr. Brennan or A/Commr. Daley. She explained that sometimes there are factors that national headquarters will

consider in accepting or rejecting a proposal, which members in the division may be unaware of:

> What happens on the ground is only but one part of the decision, and I find that happens a lot. Something comes forward, just because this person or this group things that this is the right decision, there's many other factors when I get presented things that I have to look at, so there's many other factors I have to look at that they may not be aware of. There's bigger picture items.
>
> So a decision is made. Yes, we should explain why the decision was made. It doesn't mean just because somebody wants something that we're going to agree with it. The decision's made and now the second part of that decision-making cycle is that the people on the ground have to learn how to support that decision because they might not have all the information when they decide something or when they've asked for something, and so it comes through a decision-maker, whether it's the Commanding Officer, the CrOps [Criminal Operations] Officer, a detachment commander.[135]

In her interview with the mass casualty commission, Ms. Scanlan acknowledged that some risk was associated with the RCMP's participation in the documentary and that her proposal was not universally supported:

> I think, by virtue of the fact I recommended it and the CO [commanding officer] was on board with it, yeah, I think it was an opportunity missed. But *The Fifth Estate* airs. Maybe it wasn't, that's the other thing. I understand that. There's risk in my job and I don't always make the right decision. I'm good with that. But was that an opportunity that I think we could have gone for? Sure. A lot of people disagree. My recommendation was that we did it. Darren Campbell – if Darren Campbell looked at me and said, "Lia, here's the reasons why that is a bad idea for our investigation"; done.[136]

In this exchange, Ms. Scanlan signals that she accepts national headquarter's decision despite disagreeing with it. However, the decision sparked negative reactions from Ms. Scanlan and others in H Division at the time it was made. In an October 1, 2020, email to A/Commr. Bergerman, C/Supt. Leather, and Supt.

Campbell discussing how best to communicate the decision to H Division employees, Ms. Scanlan wrote in part:

> I think if the Deputy becomes aware and wants our members to be told anything about the Fifth Estate specifically then they need to devise that message from NHQ.
>
> If the Commissioner wants the position stated it should be attributed to the Decision maker, not you or Chris. I would never fall on that sword in this situation. It would put us so many steps backwards and not to mention how bad it looks.
>
> ...
>
> It is important that no one in H implies this was their decision, it's damaging, it['s] not true and the facts will come out in the Fall when this airs.
>
> ...
>
> It is not cut and dry and I don't agree with any of it so the truth is the only thing I can resort to.[137]

The Quintet Report summarizes statements from H Division senior personnel regarding disppointment over the decision:

> Several participants mentioned that H Division had tried to "change the narrative" by providing factual statements to the media in order to counter "wildly speculative" and false stories. They said that official communications have done some of this in moderation but there was a general sense that NHQ had "muzzled" them. Several participants mentioned that Members of H Division had prepared to take part in a CBC documentary entitled 13 deadly hours: The Nova Scotia mass shooting but NHQ had stepped in and prevented it. Several participants stated that there was a general sense of being "helpless and alone," constantly criticized and attacked unfairly without being able to set the record straight.[138]

At the time, Commr. Lucki did not realize that her decision not to authorize participation in the *Fifth Estate* documentary would be taken by at least some H Division leaders as further proof of national headquarter's lack of trust in their judgment and capacity. The failure on the part of those who had more information

to recognize and squarely address the corrosive impact of this perception meant that relations among executive leaders continued to show signs of strain throughout our process. In Part C of this volume, we return to the challenges that will need to be faced by the RCMP if it is to establish a culture of internal trust and accountability.

The shortcomings in the RCMP's public communications also had an adverse impact on RCMP employees who had participated in the critical incident response. In his interview with the Commission, Cst. Stuart Beselt, one of the first four responders in Portapique on the night of April 18, 2020, shared his frustration at the RCMP's failure to provide an accurate and timely public account of the general duty members' immediate response:

> The only thing that cheesed me off is the way that, you know, with the RCMP taking like six weeks to acknowledge that we did an IARD [Immediate Action Rapid Deployment] response, you know. Because all those questions were thrown out there, like, why didn't they go in? They said they sat on the shoulder on the sidelines, didn't even go in. And they're like, yeah, we fucking went in. Like, what more do you want us to do? Like, and then it wasn't until, like, June when they came out on that press conference and by that time it was just like a, you know, you know, nobody cared anymore. Yeah, we did an IARD response. OK. Then they were moving on to other things that they had a problem with. But it was like this big thing about for a while and they never acknowledged it. And, you know, it kind of turned into a life of its own. And all they had to do at the beginning is like, yeah, members did an IARD response and were in, you know, you know, searching for the suspect.[139]

As Cst. Beselt indicates in this quote, all RCMP employees have a stake in timely and accurate public communications, particularly those whose work is the subject of public speculation and comment. After the mass casualty, RCMP employees were acutely aware of the public criticism, and the RCMP's failure to correct the public record was experienced by some employees as letting them down. In his Commission interview, Supt. Dimopoulos described the adverse impact of this perception on the work of RCMP members in the Bible Hill and Amherst detachments:

> They were upset, generally upset that there was a lot of media bashing and that a lot of criticism levelled against the RCMP or the suggestion

> that there were some leadership issues that failed them, specifically, you know, that the Force was being silent on a lot of the information that was coming out in the media. So it affected their morale, and it also affected the operational tempo of the two detachments. I mean, people were actually second guessing themselves when they were going out the calls, which caused me quite a bit of concern. And there were incidents reported to me afterwards whereby, you know, members were concerned about doing their jobs and being criticized and not supported.[140]

Supt. Dimopoulos shared these concerns with C/Supt. Leather and national headquarters in mid-June 2020. However, there appears to have been no follow up directly with RCMP employees with respect to these concerns.

Conclusion

The RCMP's executive leadership was focused on public communications in the aftermath of the mass casualty. Ultimately, the evidence we received shows a gulf between the perspectives of national leaders and those of H Division personnel on the work done by the RCMP to inform the public and responsible ministers about the mass casualty and the RCMP's critical incident response.

The RCMP's public communications after the mass casualty failed to meet the expectations of the communities and families who were most affected by the mass casualty and of the public, media, and responsible ministers at the federal and provincial levels. Some key information shared in early press conferences and news releases was wrong. In many cases, inaccuracies arose in circumstances where a more complete account of the mass casualty or the critical incident response would have reflected poorly on the RCMP's response to the mass casualty. In some instances, conflicting information was released by H Division and national headquarters, and in others, media first learned important information from community members and other non-RCMP sources. These problems contributed to growing criticisms of the RCMP's response.

Standard internal briefing practices faltered in the days after the mass casualty. There is considerable evidence that H Division personnel were conveying as much

information as they could to individual employees in national headquarters, including in circumstances where the chain of command was not being respected by national headquarters staff. H Division personnel were exhausted and emotionally affected by the mass casualty. The lack of preparedness and disorganization that characterized the critical incident response also affected the early days of the post-incident investigation as investigators scrambled to identify crime scenes, victims, and piece together a chronology of events. In many instances, because of this disarray, H Division simply could not provide better or more accurate answers to obvious questions about the mass casualty. National headquarters personnel did not recognize how much strain H Division personnel were under, and they did not step in to provide meaningful, supportive leadership. It was incumbent on H Division leadership, and national headquarters personnel who were working directly with them, to monitor the well-being and capacity of the H Division public communications team and to provide reinforcements as needed. Their failure to recognize and respond to this need was a failure of leadership.

A lack of coordination within national headquarters was ultimately responsible for many of the mis-steps that frustrated and disappointed Commr. Lucki, including a failure on the part of national headquarters personnel to provide timely updates to the commissioner and their failure to respond to H Division's request for additional support in the days and weeks after the mass casualty. Those H Division personnel who attended the April 28 meeting with Commr. Lucki felt they had been blamed for these failings, despite the efforts of some personnel to correct the record at that meeting. Supt. Campbell and C/Supt. Leather testified that these dynamics took a noticeable toll on the health and well-being of some senior H Division personnel.[141] This "cluster," as Ms. Tessier described it on April 28,[142] was allowed to fester despite the efforts of some H Division personnel to enlist national headquarters support to address it.

These dynamics were exacerbated by a lack of clear policies and standard operating procedures setting out the respective responsibilities of the commissioner, divisional and national communications personnel, and investigators on any matter of national public interest**. In future, it must be clear to the RCMP members charged with delivering information to the public that, subject to legal restrictions and the integrity of ongoing investigations, the primary objective of public communications and communications with government is to provide complete and accurate information. Other "strategic" considerations such as protecting the reputation of the RCMP or supporting other RCMP objectives may arise as secondary communications goals but must never interfere with, or be prioritized**

above, the primary goal of accurately informing the public. National headquarters must provide timely operational and communications support to a division when the division carries the primary work of meeting this responsibility in a matter of national importance. Safeguarding employee wellness requires planning for crisis communications. It may also require that further support be given to local staff, or that responsibility for public communications and internal briefing be placed elsewhere, in the wake of a traumatic or particularly complex critical incident.

The draft "RCMP Crisis Communications Reference Guide and Standard Operating Procedures"[143] offers useful guidance to communications personnel. This document suggests that RCMP national communications services have already learned some of the lessons that emerge from the mass casualty and from events that followed it. Seven years after the Civilian Review and Complaints Commission recommended a crisis communications handbook, this document comes far closer to addressing the findings made by that body than did the RCMP's 2016 response. However, this guide also has some shortcomings. It does not set out a process for the provision of additional support to divisions, nor does it incorporate the use of public warning systems into the section on communicating with the public during a crisis. It reproduces tweets sent during the mass casualty, including the initial tweet describing a "firearms complaint," as useful templates for future incidents. Most important, it is a draft document with no clear status within the RCMP policy framework. As the fate of the 2015 *C3 – Command, Control and Communications: Response and Planning Guide* produced by officers in the RCMP's Atlantic Regional Council of Criminal Operations after the MacNeil Report demonstrates, individual learning and the production of guidance documents is valuable, but adopting institutional processes to capture and retain the lessons learned from past incidents is indispensable. We return to this challenge in Volume 6, Implementation: A Shared Responsibility to Act.

LESSON LEARNED

Police agencies have an obligation to provide timely, accurate, and candid information about their work to the public.

Recommendation P.26

PUBLIC COMMUNICATIONS AFTER A CRITICAL INCIDENT

The Commission recommends that

(a) The RCMP's national communications policies should be revised to state clearly that the objective of the RCMP's public communications is to provide accurate information about the RCMP's operations, and in particular to respond to media questions in a timely and complete manner. This principle should be limited only by legal restrictions (e.g., privacy laws) and the minimum withholding necessary to protect the integrity of ongoing investigations.

IMPLEMENTATION POINTS

- RCMP employees should work toward the goal of sharing as much information as possible and as quickly as possible.
- Where information is withheld to protect the integrity of an ongoing investigation, that information must be publicly shared as soon as investigative needs no longer apply.
- Where inaccurate information is provided, a public correction must be issued as soon as the error is identified.

(b) RCMP policy and guidance should be amended to require personnel in national headquarters to assist divisional personnel with the operational and communications demands that arise after a complex critical incident or an emergency of similar scale.

IMPLEMENTATION POINTS

- When an incident has had a significant impact on divisional personnel or goes beyond the normal operations of the division, standard operating procedures should provide for additional resources to be assigned immediately to permit accurate and timely information to be conveyed to the public and to support internal briefing.

- National headquarters staff should respect pre-established reporting structures when seeking information from and issuing directions to divisional staff.

(c) The draft "RCMP Crisis Communications Reference Guide and Standard Operating Procedures" should be revised to reflect the findings and recommendations of this Report and it should be reviewed annually thereafter. This document should form the basis for mandatory training for RCMP communications personnel and officers who perform a public-facing role as spokesperson or liaison officer. These personnel should be required to review the guide regularly, and their performance should be evaluated in part by their demonstrated compliance with policy and with the principles set out in the guide.

CHAPTER 7

Issues Management and Interagency Conflict in the Post-Crisis Period

CHAPTER 7 Issues Management and Interagency Conflict in the Post-Crisis Period

In the wake of the mass casualty, the RCMP identified several issues of divisional and national importance arising from the events that required follow-up in order to brief national headquarters, develop strategic recommendations, communicate with the public, and prepare for legal or administrative processes, including an anticipated public inquiry. Some of these issues were matters of high public profile such as the 2011 Criminal Intelligence Service Nova Scotia (CISNA) bulletin about the perpetrator (2011 CISNS bulletin; also referred to as the "officer safety bulletin") and the RCMP's failure to issue an emergency alert during the mass casualty. **Shortly after the mass casualty, H Division established an Issues Management Team responsible for assisting the RCMP with several administrative priorities, including addressing these and other matters of concern.** The concept of post-crisis "issues management" was a topic of some contention in our proceedings.

In this chapter, we first discuss this concept generally and address the RCMP's early post-crisis treatment of certain significant issues – specifically, the Alert Ready system and the 2011 CISNS bulletin. **Although we address the establishment of a formal Issues Management Team in H Division, this chapter does not solely focus on that team. As set out below, other RCMP personnel, including national headquarters executives, were also engaged in efforts to address the issues with divisional and national implications arising from the mass casualty.** The RCMP hoped that its efforts at issues management would assist the organization to "gain, and in some cases re-gain, public support" after, it acknowledged, "a substantial amount of public trust [was] eroded from the incidents."[1] Other Participants in our process suggested that these efforts had the opposite impact.

The second main section of this chapter addresses the related issue of the conflict that emerged between the RCMP and some municipal police agencies related to issues of public concern arising from the mass casualty. We focus specifically on interagency conflict related to the Alert Ready system and the 2011 CISNS bulletin in the aftermath of the mass casualty.

Issues Management

"Issues management" is not addressed in detail in the RCMP policies produced to the Commission, although this function is briefly referred to in Chapter XIII.1 of the RCMP's *Administration Manual*, as well as the draft "RCMP Crisis Communications Reference Guide and Standard Operating Procedures," and in the 2014 MacNeil Report. The term "issues management" often refers to efforts by organizations to proactively identify and strategically address matters that will garner public interest or attention. The draft "RCMP Crisis Communications Reference Guide and Standard Operating Procedures" defines an "issue" as follows:

> Crisis vs. Issue
>
> In contrast to a crisis, an issue is typically long-standing, slow to develop, and often predictable. It can be identified, monitored and managed as it evolves. The longer it evolves, the more likely it is to be made public by activists, supporters or media.[2]

Issues management is often connected to an organization's public relations function (the RCMP, for instance, groups "Media Relations, Issues Management, and Social Media" under a single national director), but the terms are not synonymous. Public communications is one of several approaches and means, or tools, that an organization may use to proactively address an issue of concern with its stakeholders.

After the mass casualty, the RCMP identified several matters of divisional and national importance requiring administrative follow-up. C/Supt. Christopher (Chris) Leather explained that it was "fairly obvious what the issues should be and what we needed to identify and begin to work on." He acknowledged that some of the issues (for example, the 2011 CISNS bulletin, the Alert Ready system, and the 2013 Brenda Forbes complaint) were of concern because of their potentially negative reputational implications for the RCMP. A/Commr. Lee Bergerman explained that the RCMP needed to research and "flesh out"[3] the significant issues arising from the mass casualty "so that we could accurately answer the questions that were being asked of us."[4] She used the issue of decommissioning police cars as an example, noting that research was required to understand how police cars are decommissioned and to answer questions about how the perpetrator was able to obtain four decommissioned RCMP cruisers.

Proactively identifying matters of public concern after a crisis and providing consistent, accurate, and balanced information on those issues can positively impact public trust. Prompt steps to understand broader or systemic problems exposed by a crisis can also help an organization to identify needed changes to policy.[5] **However, it is critical that police agencies approach the task of "issues management" – including in relation to controversial matters – with an attention to accuracy and transparency that is consistent with their unique public responsibilities. The reputational or other interests of the police organization must never be permitted to compromise the public interest in accurate study and reporting on matters of public safety.**

As the following sections of this chapter explain, the RCMP's approach to sensitive issues of public interest arising from the mass casualty did not always adhere to this principle. We illustrate this pattern with the example of the RCMP's work involving the Alert Ready system. After the mass casualty, the RCMP expended considerable efforts to compile and report information about potential flaws of the Alert Ready system but did not make comparable efforts to understand and explain the public safety benefits of the system. The RCMP's post-crisis communications about this issue (both internally and externally) relied on incomplete and partially inaccurate information about the impacts of using Alert Ready on Nova Scotia's 911 system.

Before addressing Alert Ready, we discuss the establishment of H Division's Issues Management Team, including disagreement between the RCMP and the province over funding for the team.

Establishing an Issues Management Team in H Division

After the mass casualty, the pressures to manage the issues of divisional and national importance arising from the crisis, as well as other administrative tasks flowing from the events, exceeded H Division's capacity. As the RCMP explained in a July 2020 request for additional provincial funding, H Division had "insufficient capacity" to "effectively manage the sensitive and complex administrative workflow related to this [mass casualty] investigation"[6] and "[t]here [was] no team currently within 'H' Division who ha[d] the capacity to effectively manage the key issues identified."[7] As a result, H Division required additional resources to staff an

Issues Management Team. The RCMP and the province disagreed over who should bear the responsibility to fund these additional positions.

The Issues Management Team was established shortly after the mass casualty. It "did not have an operational or investigative mandate" but was responsible for addressing "the Divisional issues and those with National implications" arising from the mass casualty.[8] The team was somewhat of an institutional innovation. Before the mass casualty, "the creation of a post tragedy formal Issues Management Team ha[d] not previously been implemented within the RCMP."[9] H Division initially brought in two RCMP superintendents from other provinces to lead the Issues Management Team, specifically Supt. Derek Santosuosso, the officer in charge of support services for B Division (Newfoundland and Labrador), and Supt. Constantine (Costa) Dimopoulos, the officer In charge of specialized policing services for J Division (New Brunswick). One impetus for creating this team was the concerns raised by Commr. Brenda Lucki in the April 28, 2020, meeting regarding the flow of information about the mass casualty from H Division to national headquarters. On April 29, 2020, C/Supt. Leather wrote to A/Commr. Dennis Daley as follows:

> It became very clear during our TC [teleconference] with the Commissioner and D/Commissioner yesterday evening, that we are not meeting their reporting requirements / needs. Very soon, we will need input and support from C+IP [Contract and Indigenous Policing] on the myriad of current and future issues.
>
> We are constructing an Issues Management Team in the Division and have drafted in Supt's Dimopoulos from JDIV [New Brunswick] and Santosuosso from BDIV [Newfoundland and Labrador] given their historical involvement in Moncton and IHIT / MCU [Integrated Homicide Investigation Team / Major Crimes Unit] to assist and oversee this.
>
> While I recognize many of your staff are engaged with COVID-19, we will require support and communications with the Centre, so we can better understand what the NHQ [national headquarters] daily priorities and needs are.
>
> I look forward to discussing with you at your earliest convenience.[10]

The purpose, scope, and staffing of the Issues Management Team were points of contention in our proceedings. Counsel for the RCMP initially took the position

that information about the staffing of the Issues Management Team was protected by litigation privilege because it was "formed to respond to the anticipated joint review / inquiry."[11] Litigation privilege, discussed in Chapter 4 of Volume 7, Process, is a legal privilege that applies when a document is not subject to disclosure because it is created for the dominant purpose of existing or anticipated litigation. When evidence from RCMP witnesses made it clear that the scope of the Issues Management Team's work was broader than counsel's position suggested, counsel for the RCMP adopted a more expansive description of the purpose of the Issues Management Team: "The H Division Issues Management Team was to be responsible for effectively coordinating the short and long term key issues locally, divisionally, and nationally."[12] In final submissions, counsel for the RCMP stated that the Issues Management Team was set up to deal with a wide range of policy issues stemming from the mass casualty, and its work included reporting to national headquarters and identifying "necessary policy changes or other remedial action."[13] However, others outside the RCMP suggested that the Issues Management Team was primarily focused on seeking to influence public narratives regarding matters that might reflect poorly on the RCMP.

The evidence we received suggests that the team's responsibilities included compiling information about the mass casualty and related matters of significance in order to brief national headquarters, provide "strategic considerations and recommendations" for the RCMP, communicate with the public, and prepare for an anticipated public inquiry about the mass casualty. The Issues Management Team was also responsible for collecting and preserving documents for potential disclosure in legal or administrative processes related to the mass casualty, including the anticipated public inquiry. As we explained in Chapter 5 of this volume, Supt. Dimopoulos also took some steps toward conducting operational debriefings of RCMP personnel who responded to the mass casualty.

C/Supt. Leather described the purpose of the Issues Management Team as follows:

> The focus there was to, first of all, understand the issues and be able to report on it in a thorough and objective way to wherever in our governance, again Provincial Government, National Headquarters. And then to provide strategic considerations and recommendations on how on a go-forward. And we certainly did that in the two, in the [CISNS] Officer Safety Bulletin and Alerting.[14]

Similarly, Supt. Dimopoulos explained that while the Issues Management Team was "not there to create policy," the team was expected to "identify issues, [and] bring them forward to the appropriate policy holder for follow up action."[15] A/Commr. Bergerman stated it was important to be able to "flesh all these things out" in order to communicate information "not only with the public, but with National Headquarters."[16]

The question of whether the Issues Management Team participated in the development of public messaging related to the mass casualty was also contentious. A May 4, 2020, email from Supt. Santosuosso outlining the mandate of the Issues Management Team identifies communications as one of the "major issues" within its purview:

> Some of the major issues are:
>
> ...
>
> Corporate Communications: There significant pressure [*sic*] internally, externally and politically regarding communication on a variety of issues and the shaping of the outcomes and the messaging in support of a variety of agendas.[17]

A May 6, 2020, email from H Division strategic communications advisor Cindy Bayers also states that all media responses not directly related to the RCMP's criminal investigation of the mass casualty required review by the Issues Management Team or C/Supt. Leather. Supt. Dimopoulos acknowledged that the team did assist with public communications but this was not its only function. However, Supt. Dimopoulos emphasized that "we weren't there to spin doctor anything or hide anything."[18] To the contrary, Supt. Dimopoulos advised the Commission that he favoured proactive public disclosure about sensitive issues such as the 2011 CISNS bulletin because "by not saying anything, all we're doing is contributing to a media frenzy and a false narrative and a distraction to the investigation."[19] As we address later in this chapter, national headquarters decided against proactively disclosing the 2011 CISNS bulletin to the public after the mass casualty.

Although the Issues Management Team compiled information and provided strategic input on several issues related to the mass casualty, the team's focus was not on identifying lessons learned from the events of April 18 and 19, 2020, or the perpetrator's interactions with police that preceded it. As C/Supt. Leather stated, the Issues Management Team was not set up "to investigate or probe or review"

the past actions of the RCMP or to duplicate the H-Strong investigation. Supt. Dimopoulos confirmed this point, in particular as it concerned the 2011 CISNS bulletin:

> COMMISSION COUNSEL: Did anybody, including yourself, turn your mind to the bulletin and whether it represented a missed opportunity for intervention or any kind of follow up with respect to the perpetrator by the RCMP? Did anyone have a look at the bulletin in that regard?
>
> SUPT. COSTA DIMOPOULOS: Not from an Issues Management perspective, I think that that opportunity certainly would have presented itself later on through a formal review.
>
> ...
>
> COMMISSION COUNSEL: And my question to you was, and we'll touch on this in more detail later, but just while you raised it, do you recall discussions about doing that sort of review while you were at H Division?
>
> SUPT. COSTA DIMOPOULOS: No.
>
> COMMISSION COUNSEL: But I take it you didn't see the role of the IMT [Issues Management Team] as being to look at whether the Officer Safety Bulletin represented that missed opportunity, right?
>
> SUPT. COSTA DIMOPOULOS: Not at that time, no.[20]

At some point, the Issues Management Team transitioned into a team referred to as "H-Strong II," although the precise date when this new name took effect is unclear. H-Strong II primarily focused on managing the RCMP's response to the Mass Casualty Commission. Whereas the Issues Management Team had reported to the H Division criminal operations (CrOps) officer, H-Strong II reported directly to Contract and Indigenous Policing at national headquarters, with a "dotted line" reporting relationship to the H Division commanding officer.

Funding for the Issues Management Team

The responsibility for funding additional resources required to staff the Issues Management Team was a point of disagreement between the RCMP and the

province. RCMP national headquarters did not want to fund the Issues Management Team, despite part of the team's function being to respond to national headquarters' briefing needs. H Division submitted a business case dated July 21, 2020, to the province requesting funding for the Issues Management Team. Attorney General and Minister of Justice Mark Furey rejected the request for additional funding by letter dated October 28, 2020. He stated: "[T]here is no contractual obligation for the province to financially support this proposal"; and, "Each contracting jurisdiction already pays a proportionate share toward legal advisory services in direct support of the policing service within the cost base." The letter concludes, "[I]f the decision operationally is to continue with the team, then costs must be absorbed within your existing cap funding for this fiscal year."[21]

A/Commr. Bergerman requested on December 1, 2020, that Mr. Furey reconsider his decision not to provide funding for the Issues Management Team. Mr. Furey responded by letter dated December 11, 2020, stating, "While I am unprepared to accommodate your request as proposed in the Business Case dated July 2020, I'd ask that you provide additional information regarding the significant changes to the [Issues Management Team] composition and responsibilities you reference in your December 1 letter."[22] The Commission is not aware of any response from A/Commr. Bergerman.

C/Supt. Leather told the Commission that the Issues Management Team was ultimately funded by the province. The budget for the team came out of H Division Criminal Operations.

In April 2021, H Division made a further request for additional provincial funding for the Issues Management Team / H-Strong II. By that time, the Issues Management Team had morphed into H-Strong II, which primarily focused on responding to the Mass Casualty Commission. The province again declined H Division's request for additional funding to resource this team.

However, with the exception of the Office in Charge of H-Strong II (which reports to, and is funded by, national headquarters), the full-time resources dedicated to H-Strong II were funded provincially. The RCMP explained in written evidence that each of these six full-time resources "has been displaced from their substantive role due to the high priority of this matter, leaving a vacancy that is necessary to back fill to continue and fulfill service delivery."[23]

Mr. Furey expressed disappointment that despite his refusal to approve provincial funding for the Issues Management Team / H-Strong II, the province did

end up partially funding these resources. He explained that H Division would have obtained additional provincial funding for these resources by invoicing the province via the "appropriation process." (Through this process, the responsible minister applies to the Treasury Board for approval of additional funding for a government service provider that has exceeded its budget.[24]) Mr. Furey was of the view that the RCMP "consciously took advantage of the 'appropriation' process in government" by submitting invoicing for these resources.[25] In Part C of this volume, we return to the difficulties that arise for contracting provinces when seeking to manage costs and service levels and ensure that the RCMP implements provincial policing priorities. We also explore some of the limitations on the province's ability to practically influence which RCMP programs or resources are prioritized by the division.

RCMP Approach to the Alert Ready System in the Immediate Post–Crisis Period

After the mass casualty, a great deal of public attention was directed toward the question of whether the Alert Ready system should have been used to warn the public while the perpetrator was at large. Prompted by media scrutiny on this issue, the Alert Ready system became a significant focus for H Division and RCMP national headquarters.

D/Commr. Brian Brennan explained that after the mass casualty, the RCMP "were putting a lot of effort into being able to position themselves as to why the … or the decisions around why the [Alert Ready] system wasn't used immediately and the limitations of the system and the fact that it never had been used in a policing operational environment before."[26] Supt. Dimopoulos stated that the Issues Management Team was focused on "trying to understand what the [Alert Ready] system does, what its limitations are, like we were provided information with regards to its limitations and its impact on the 911 system."[27] He did not recall, however, seeking any information about the system's strengths, and the Issues Management Team did not consider whether Alert Ready could have made a difference

in the mass casualty event. **Consistent with this evidence, RCMP briefing materials tended to focus on identifying flaws with Alert Ready, with little evidence of efforts by the RCMP to consider the benefits of the system, including whether it might be a life-saving tool during a mobile active shooter incident.**

According to the RCMP, one of the major risks of using the Alert Ready system was the potential impact of an alert on 911 call volumes. These concerns arose primarily from the RCMP's use of the Alert Ready system five days after the mass casualty on April 24, 2020, in response to an unrelated incident.

On April 24, 2020, H Division issued a public alert in relation to a report of shots fired in the Tantallon area of the Halifax Regional Municipality. The following day, H Division sent a Situation Report to RCMP national headquarters containing strong warnings about the impact of issuing the alert on 911 call volumes. The Situation Report stated that following the alert, the Operational Communications Centre was "overwhelmed" by 911 calls, and 29 percent of calls were not processed as a result. The Situation Report also stated that the public safety answering point for Halifax District, Integrated Emergency Services (IES), was also "inundated" with calls during the alert period. The Situation Report speculated that the 911 system might have been similarly overloaded on April 18 and 19, 2020, if the RCMP had issued an alert during the mass casualty. H Division reported the same information in Situation Reports to the Nova Scotia Attorney General, the Nova Scotia Chiefs of Police, and the federal minister of public safety and emergency preparedness. Following the April 24 alert, H Division discussed its concerns about the Alert Ready system with the province. H Division told the province that the RCMP would be unlikely to use the Alert Ready system in the future and asked the province to urgently issue public messaging about the possible negative impacts of using the system.

Mr. Furey explained that he did not accept the RCMP's assertions about the impact of Alert Ready on the 911 system and was not prepared to issue public messaging on the RCMP's behalf. Despite the RCMP's report that the 911 call centre in Halifax was "inundated" by calls following the April 24, 2020, alert, Mr. Furey stated that he was advised by Halifax Regional Municipality and Halifax Regional Police that this was not the case.

The statistic that 29 percent of 911 calls were not processed during the alert period on April 24, 2020, appears in several RCMP documents, including both internal briefing materials and documents shared with external stakeholders. Without further context, this statement presents an inaccurate picture of the fate of these calls. Any calls that go unanswered by the RCMP's Operational Communications

Centre are automatically rerouted to another public safety answering point (such as the Halifax Integrated Emergency Services dispatch centre, in accordance with the province's 911 overflow system). The RCMP does not manage these other public safety answering points, and so it does not know whether or how quickly those calls were answered by other centres once they were rerouted. Insp. Dustine Rodier explained this system in an email dated May 1, 2020. Her email indicates that information about the 911 overflow system was included in her "original draft BN [briefing note]." However, this information was not included in the Situation Reports referenced above, which were provided to national headquarters, the federal and provincial governments, and municipal police chiefs after the April 24, 2020, alert. Insp. Rodier's email states:

> Processed means calls that the OCC [Operational Communications Centre] received the 911 call and the calls were answered by our operators.
>
> Not processed means the call was automatically transferred to another PSAP to be processed or the caller hung up, resulting in an abandoned 911 call. NS EMO [Emergency Management Office] holds the data on these calls, we do not have access to what happened to the calls that were not processed.
>
> This is the sentence I had in my original draft BN [briefing note] if it helps:
>
> "The OCC staff were only able to process 131 of these calls, even with the addition of an extra call taker. The remaining unanswered calls were automatically downloaded to other three Public Safety Answering Points (PSAPs) throughout the Province. This represents 29% of the calls to the H Division OCC were not processed."[28]

An April 30, 2020, email from Insp. Rodier to Glen Byrne, commander of the H Division Operational Communications Centre, also explains the 911 overflow system, in part:

> Each PSAP has automatic backup for overflow 911 calls. In the event a particular PSAP is inundated with 911 calls, any further incoming 911 calls will automatically be rerouted to the next PSAP. For example, H Division OCC is the backup for IES [Integrated Emergency Services], Valley is the backup to H Division OCC, IES is the backup for Valley and then, Cape Breton.

> If a caller was to dial 911 to report an emergency in North East Nova and all of the H Division 911 calltakers were busy, the call would automatically be re-routed to Valley PSAP. If Valley PSAP was unable to answer due to call volume, the call would be transferred to IES, and so on.
>
> ...
>
> ... If a call for our jurisdiction was answered by any of the other PSAPs, the respective PSAP would then transfer the caller back to our police emergency line and wait on the line with the caller until one of our operators could answer.[29]

In her evidence before the Commission, Supt. Rodier initially testified to "seeing a 29 percent in abandoned [911] calls" after the RCMP issued an alert. However, she later clarified that these calls were not necessarily abandoned. Rather, consistent with her above emails, the calls were simply rerouted to other Public Service Answering Points. The RCMP cannot know whether or how quickly those calls were answered after being rerouted:

> PARTICIPANT COUNSEL: – again, just on the 29 percent, so again, we don't know if, in fact, that 29 percent of calls could have been completely processed.
>
> SUPT. DUSTINE RODIER: We don't – there's no way to tell.[30]

Supt. Rodier explained that once overflow calls are answered by another public safety answering point, they will still need to be sent back to the PSAP in the jurisdiction the call originated from if dispatch is required. The 911 call taker at the overflow PSAP cannot start the process of creating a dispatch file and sending it to the responsible police agency because different agencies use different dispatch and records management systems.

The Situation Reports distributed by the RCMP after April 24, 2020, noted that in addition to the impact on the RCMP's Operational Communications Centre, the Integrated Emergency Services dispatch centre in Halifax Regional Municipality "confirmed they were also inundated with calls during the Alert period" on April 24, 2020. However, a briefing note dated April 27, 2020, prepared by the Integrated Emergency Services dispatch centre shift supervisor, Insp. Greg Robertson, and addressed to both Halifax Regional Police and the RCMP, indicates that this claim was an oversimplification.[31] The briefing note documents that the IES "had a high

[call] volume for a fair bit of the afternoon" on which the alert was issued regarding several incidents, and that call volume had already increased with respect to the Tantallon incident before the alert went out.[32] Insp. Robertson does not suggest that the volume exceeded IES capacity. He also expressed doubt about whether the alert was in fact the cause of the high volume of calls, stating, "I am not sure if the alert was totally the reason for the increase in calls as there was a ton of ridiculous info being shared on social media platforms as well."[33] The briefing note concludes:

> I think the public education piece, combined with a specific location / area in future alerts, as well as something in the alert to advise not to call 911 unless xyz would prevent a surge in calls and address the concerns over an increase in call volume overall in the future.
>
> I realize the alert may tax us operationally for a short time but if we do have an active shooter, the ensuing results could be far more taxing. In a real situation, an alert may save a life.[34]

Although the RCMP did have data regarding the number of 911 calls that were rerouted by the 911 overflow system after the April 24, 2020, alert, it did not have evidence that any 911 calls were "dropped" or went "unanswered." The RCMP did acknowledge in a May 7, 2020, Situation Report to the Nova Scotia Attorney General that on April 24, 2020, the 911 calls that were not answered by the Operational Communications Centre "were diverted per standard procedure to one of the other three Primary Service Answering Points in Nova Scotia."[35] **However, C/Supt. Leather advised the public on June 4, 2020, that following the April 24, 2020, alert, "many calls were not answered at all because of the call volumes" and** "[t]his **had a negative impact on public safety, and what I mean is, that people who had true emergencies may not have gotten through to the 911 operators."**[36] In internal briefing materials including, for instance, a January 2021 presentation to the RCMP Operations Committee and a March 2021 Issues Management Team Report titled "IMT [Issues Management Team] Final Version DOJ [Department of Justice] Alert Ready Document, the RCMP also reported that 29 percent of 911 calls on April 24, 2020, were "dropped" or "unanswered." As well, the RCMP appears to have provided this information to KPMG, a consulting firm that authored a May 2022 report for the RCMP about Alert Ready. This report indicates that the RCMP identified potential impacts on the 911 system as a risk of using Alert Ready, relying

in part on the RCMP's experience on April 24, 2020, when 29 percent of 911 calls were "abandoned." This report is discussed further in the following section.

KPMG Report

H Division retained KPMG to author a report titled Risk Analysis and Mitigation Strategy Related to Activation of the Nova Scotia Public Alerting System (the KPMG Report).[37] The report was completed on May 9, 2022.

Counsel for the RCMP submitted that the KPMG Report "is not an effort to say that the Alert Ready is not a good thing." Rather, the purpose of the report was "to learn more about Alert Ready" and to "find out what the potential problems are" and "try and mitigate the risks."[38] Supt. Rodier explained in her testimony that, because the report was completed "well after" the RCMP had developed policies on Alert Ready, the RCMP did not use the KPMG Report to inform its Alert Ready policies.

As set out in the KPMG Report, the report's purpose was to present risks of using the Alert Ready system which had been identified by the RCMP and to summarize the RCMP's assessment of its risk mitigation strategies:

> The purpose of this report is to present the risks defined and ranked by the RCMP associated with the utilization of the public alerting system for police-related serious incidents in Nova Scotia in consideration of current risk mitigations. The objective of the report is to summarize the results of RCMP's identification and assessment of potential risk mitigation enhancements and to consider the feasibility of use by the RCMP for police related serious incidents.[39]

The KPMG Report did not consider any potential benefits of using Alert Ready: "The scope of this report excluded analysis of the potential benefits of use of Alert Ready for police serious incidents."

The report states that the "RCMP identified 24 key risks, in consultation with NSEMO [Nova Scotia Emergency Management Office], related to the activation of the national Public Alerting System for police-related serious incidents." The RCMP also identified the "root cause driver for each risk and the potential implications to the RCMP." The report rates on a 5-point scale the "velocity," "likelihood,"

and "impact" of each risk identified by the RCMP and assigns an "overall score" to each risk, based on the combined "impact" and "likelihood" scores. These risk ratings, however, were not determined by KPMG but were arrived at through a voting process. Specifically, unidentified RCMP representatives voted on what number to assign each risk. For those risks that impacted the Nova Scotia Emergency Management Office, representatives from that office voted along with the RCMP representatives. Once the votes were tallied, the participants rounded the average scores up or down to whole numbers through a process of consensus. Although KPMG recorded these ratings, it did not independently assess them. Risks were then plotted on a "heat map" based on these numerical rankings.

As noted above, the KPMG Report records inaccurately that 29 percent of calls were "abandoned by the caller" after the April 24, 2020, alert. The report also relies on information provided by the RCMP that "[a]lerts may cause mass panic, citizens taking up arms, going to the incident site to view, sharing officer locations / activities, purposely providing false information, etc., impacting safety and potentially impeding RCMP operations and investigations."[40] The misconception that the public will descend into "mass panic" in response to an alert was challenged during the Commission's process and is addressed in Chapter 4 of this volume and in Volume 4, Community.

The KPMG Report also contains a "Feasibility Review" based on the risk analysis (described above) and on relevant RCMP policies or other factors that mitigate against those risks. To arrive at conclusions about the feasibility of the RCMP using the Alert Ready system, KPMG identified "the degree of alignment" between (1) the risks of using Alert Ready (identified by the RCMP and assessed via the voting process described above); and (2) relevant current and future mitigation measures or factors identified by the RCMP. In drawing its conclusions, "KPMG did not assess the design or operating effectiveness of the current mitigations," nor did KPMG "identify or assess the benefits of activation of Alert Ready."[41] With these caveats, the Feasibility Review concludes that "Alert Ready appears to be a feasible tool for RCMP to use during serious incidents; however, risk remains high in some areas." The report notes that "activation of Alert Ready for serious incidents is event specific"; and:

> Activation of alerting needs to be assessed during each serious incident given the incident's facts and circumstances and in consideration of the risks and impacts to public safety, officer safety, first responder safety, RCMP operations, ongoing investigation, and OCC and 911 Operations.[42]

Although the KPMG process appears to have provided a structure through which the RCMP could identify and proactively seek to mitigate potential risks associated with the use of Alert Ready, it neither evaluates the benefits of Alert Ready nor offers any independent evaluation of identified risks and mitigation strategies. There is no evidence that the KPMG or RCMP personnel involved with the KPMG Report have particular expertise with the design and use of public warning systems. Overall, the KPMG Report reproduces the RCMP's pre-existing narratives about the risks of Alert Ready, with the expressed intention that the report will be shared "with the MCC [Mass Casualty Commission] and will form the foundation for recommendations on the use of public alerting for police involved serious incidents in Nova Scotia and nationally."[43] However, the report also contains the following disclaimer: "KPMG neither warrants nor represents that the information contained in this report is accurate, complete, sufficient or appropriate for use by any party or entity other than the RCMP for any purpose other than set out in our Statement of Work with the RCMP."[44] Counsel for the RCMP placed no reliance on the KPMG Report in final oral or written submissions. **The KPMG process illustrates H Division's persistent focus on documenting the dangers that, H Division suggests, arise from the use of Alert Ready, and the lack of organizational attention to capturing the benefits and potential of Alert Ready.**

Interagency Conflict Related to Alert Ready

Alert Ready became a point of conflict between H Division and some municipal police agencies in Nova Scotia in the aftermath of the mass casualty. Some municipal police chiefs gained the impression that H Division was attempting to persuade municipal police to support H Division's position that the Alert Ready system was flawed. However, RCMP witnesses insisted they never tried to push that position on the municipal police chiefs. Much of this evidence centres on an April 30, 2020, teleconference among H Division senior officers, Issues Management Team members, and municipal police leadership.

As noted above, following the April 24, 2020, alert, H Division sent a Situation Report to the municipal police chiefs regarding H Division's concerns about the

Alert Ready system, including its impact on the 911 system. H Division subsequently arranged a teleconference with municipal police leadership on April 30, 2020, to discuss Alert Ready. Before this teleconference, Chief David MacNeil of Truro Police spoke to several other municipal chiefs to discuss how they would respond if the RCMP asked them to support a position that the Alert Ready system was flawed and not suitable for police use:

> So I talked to a few other chiefs prior to the call and said this is where I'm at with it, you guys can vote to do whatever you want, but I'm not signing on to this. This, this stinks. This is … not cool. So anyway, they all agreed.[45]

At the April 30, 2020, teleconference, the RCMP presented their concerns about the Alert Ready system to the municipal chiefs. Cape Breton Regional Police Chief Robert Walsh told the Commission that there were differences of opinion about Alert Ready. He stated, "the RCMP indicated that they didn't use it because they thought the system was flawed and it would overload the 911 system."[46] Chief Walsh did not share this view. Julia Cecchetto, at the time the chief of Kentville Police and president of Nova Scotia Chiefs of Police Association, told the Commission that during the April 30 teleconference, the municipal police chiefs were asked by the RCMP "if we were willing to basically support [the RCMP] on saying the Alert Ready system was flawed." Chief Cecchetto explained that the "Nova Scotia Chiefs did not support them in saying that the system did not work because we were not necessarily of that opinion."[47]

Daniel (Dan) Kinsella, Halifax Regional Police chief, also had the impression that the RCMP was attempting to garner support from the municipal chiefs regarding their position that Alert Ready was not a suitable tool for police during an event such as the mass casualty. He stated in his written evidence:

> The entire issue of the re-evaluation of the Alert Ready system suddenly raised by the RCMP immediately after they didn't avail themselves of the tool was baffling. On April 24th (just days after the MC [mass casualty]), a memo was sent to NS Chiefs focused on Alert Ready, followed by an RCMP request for a conference call on April 30th to discuss perceived problems with the Alert Ready system. The gist of the conference call appeared to be an attempt by the RCMP to characterize the Alert Ready system as being inadequate to the point of uselessness in the mass casualty. They seemed to be looking for agreement or support from the

> NS Chiefs with this assessment. The focus on this very specific topic at this meeting with the Chiefs seemed misplaced, given the gravity of the overall incident, and given that the alerting tool was always available for use, especially in light of the fact that a provincial alert had been sent just the previous week relating to COVID.[48]

Chief MacNeil also testified that "the RCMP leadership, you know, wanted the Nova Scotia Chiefs to endorse that the Alert Ready system doesn't work in the province, it fundamentally doesn't work for police use." However, he continued, the "Nova Scotia Chiefs disagreed with that narrative, and we suggested that we weren't going to support that publicly."[49] In his Commission interview, Chief MacNeil described the April 30, 2020, teleconference as follows:

> Lee Bergerman and Chris Leather had a conference call with all the chiefs. And basically, she was trying to paint the narrative that the Alert Ready system doesn't work. It's not effective. It's not friendly for law enforcement. And we all need to get on board as Nova Scotia chiefs and say this publicly that we would never use it, it is not set up to do what the public thinks it will do.
>
> ...
>
> So we had a very quick telephone conference where Lee Bergerman laid out her narrative and basically wanted the Nova Scotia Chiefs to join in unison with this RCMP narrative that system doesn't work and it's not law enforcement friendly and it doesn't provide the tools that we need and it crashes the 911 system for all these people will call and all this kind of stuff. So we all agreed, hey, you know what? We're pretty content with the way it is now. We've used it for missing persons. We use it for other things. We're not going to be adapting that narrative. Well, you could, the tone of the call changed like that.[50]

Mr. Furey also told the Commission that following the mass casualty, he received reports from municipal police chiefs that the RCMP "was trying to convince our Municipal Chiefs not to use Ready Alert."[51] According to Mr. Furey, the municipal chiefs who spoke with him advised "that they were not buying into that position."[52] Mr. Furey explained that the chiefs "wanted to assure me, as the Minister of Justice, that they, as a municipal police department, would continue to use Ready Alert [*sic*], if and when required."[53]

RCMP executives disagreed that they attempted to persuade the municipal chiefs to adopt a negative position on Alert Ready. A/Commr. Bergerman said the discussion at the April 30 teleconference "was more around the 911 call centres and to be, and to know the risks associated with it."[54] C/Supt. Janis Gray, Halifax District RCMP commander, stated, "We never asked the NS Chiefs either through the working group nor again, any conversation or meetings I was involved in, to agree to anything."[55] C/Supt. Leather told the Commission that he "wanted the Chiefs to be aware of … the results of the analysis that we did after that alert was issued [on April 24]." Although he described the April 24, 2020, alert as "a cautionary tale to the Chiefs on the call,"[56] he disagreed that the RCMP tried to persuade municipal police to adopt a negative narrative about the Alert Ready system:

> COMMISSION COUNSEL: So I can show you the transcripts if you wish, but according to Chiefs MacNeil and Chief Cecchetto in their Mass Casualty interviews, they were under the impression that the RCMP wanted to have a narrative that the Alert Ready system didn't work; it's not effective and wanted the Nova Scotia Chiefs to agree with that publicly. Is that right?
>
> C/Supt. CHRIS LEATHER: No, that's not correct.
>
> COMMISSION COUNSEL: So what's your perspective on that?
>
> C/Supt. CHRIS LEATHER: I raised concerns about the whole alert system with the limited knowledge and understanding of the technology that we had in April of 2020. And I had concerns about using it again without further analysis and understanding of the technology. I was bringing my concerns to the Chiefs' attention because I was pretty certain that none of them had experienced the issuance of an alert. And if I remember correctly, this call was after the call in HRM [Halifax Regional Municipality] with the shots fired situation where we did issue an alert in the Halifax area.
>
> COMMISSION COUNSEL: So on April 24th, 2020?
>
> C/Supt. CHRIS LEATHER: And this call you're talking about was April 30th?
>
> COMMISSION COUNSEL: Yes.

> C/Supt. CHRIS LEATHER: So I was sharing with them, and I don't have the minutes in front of me, but that would have compelled me to bring them up to speed on what had happened pursuant to that issuance of the alert so they could understand the impacts. Again, we were just beginning to learn what the impacts were and that we needed to be cautious in using an alert and understand the downstream effects of when we do so.[57]

C/Supt. Leather acknowledged in his Commission interview that at least some municipal police chiefs who attended the teleconference were clearly not persuaded by the RCMP's cautions about the risks of using Alert Ready:

> And it was clear … I remember two Chiefs in particular, Kinsella and Walsh coming out strongly to say that they will continue to use alerts and thank you for the update, but yeah, it really doesn't have any impact on their, on their decision to use or not.[58]

C/Supt. Leather testified that the municipal police chiefs' perception of the April 30, 2020, teleconference reflects "bigger issues in terms of relationships, [and] trust."[59]

> COMMISSION COUNSEL: Just back to the Alert Ready system conversation with the Chiefs, for example, my impression of their perception was that they thought the RCMP was trying to discount the effectiveness of the Alert Ready system to reduce criticism for not having used it on April 18th and 19th 2020. Is that what you were trying to do in that call?
>
> C/Supt. CHRIS LEATHER: No. Perhaps it is how it was perceived. Well, obviously it was perceived that way if that's the testimony that's been received. But that was not the intention of the call, nor was that the message. And what can you say about that? That was not what we said. And if that was the takeaway, it's unfortunate and it speaks to – it speaks to bigger issues in terms of relationships, trust, and that's what it does, because, again, it's not just that call in isolation. It's then the call several months later dealing with a completely different issue. And actually, some of the same Chiefs, but some different as well. And it was obvious that some of those sentiments continued, and it made for a difficult call, unnecessarily difficult, when all it was in that call, which the

> CO [Commanding Officer] was not part of, the one about the timeline around the officer safety bulletin, an uphill battle from start to finish on all items.[60]

The "unnecessarily difficult" phone call between H Division and municipal police that C/Supt. Leather referred to is a May 14, 2020, teleconference related to the 2011 CISNS Bulletin. We discuss that interagency meeting further below.

Interagency Conflict Related to the 2011 CISNS Bulletin

Along with Alert Ready, the 2011 CISNS bulletin became a point of significant conflict among police agencies after the mass casualty. As set out in Volume 3, Violence, an officer safety bulletin warning police about the perpetrator was disseminated to Nova Scotia police agencies about a decade before the mass casualty. The events surrounding the issuance of and lack of investigation prompted by the 2011 CISNS bulletin are addressed in Volume 3, Violence. This section focuses on points of interagency controversy related to the 2011 CISNS bulletin after the mass casualty.

On April 19, 2020, a member of the Amherst Police Department located the 2011 CISNS bulletin, which originated with information obtained by Truro Police Service. Amherst Police Chief Dwayne Pike explained to the Commission that, after learning the perpetrator's name, Cst. Mark McNair recalled the 2011 CISNS bulletin and found a copy of it in his email. Chief Pike recalled that Cst. McNair sent the 2011 CISNS bulletin to another Amherst member, who provided it to Amherst member Cst. Chris Jobe. Cst. Jobe then advised his friend, RCMP Cst. Shawn Himmelman, of the 2011 CISNS bulletin on the evening of April 19, 2020. The 2011 CISNS bulletin was sent to several other RCMP members before H Division management received it on April 21, 2020, at 1:14 pm. After the bulletin came to their attention, the RCMP also located it in a Criminal Intelligence Service Nova Scotia (CISNS) shared drive. The 2011 CISNS bulletin was identified in the CISNS shared drive within days of the mass casualty.

In Volume 3, Violence, we explained that the Criminal Intelligence Service Nova Scotia issued a bulletin about police officer safety in May 2011 on the basis of information received by Cpl. Gregory (Greg) Densmore of Truro Police Service. The 2011 CISNS bulletin warned police to use extreme caution when dealing with the perpetrator:

> Information has been received that [the perpetrator] … stated he wants to kill a cop. [The perpetrator] is in possession of at least one handgun and may be transporting this firearm back and forth between 193 Portland St. in Dartmouth and 200 Portapique Beach Rd., Portapique, Colchester County, NS.
>
> [The perpetrator] may also be in possession of several long rifles located at his cottage at 200 Portapique Beach Rd. These firearms are stored in a compartment located behind the flue.
>
> Police have been advised [the perpetrator] is upset over a break and enter complaint he filed, is under a lot of stress, and has mental issues.
>
> Use extreme caution when dealing with [the perpetrator].[61]

In Volume 3, Violence, we conclude that there is no evidence that the 2011 CISNS bulletin led to any meaningful investigation of the perpetrator by any police service. It also was not provided to the Canada Border Services Agency. This missed intervention point is notable in part because of the officer safety aspect it entailed.

April 24, 2020, Teleconference Between RCMP and Truro Police Service

The 2011 CISNS bulletin was initiated by Cpl. Greg Densmore of Truro Police Service, who in 2011 requested that CISNS create the bulletin. At that time, CISNS circulated it to police in Nova Scotia. On April 24, 2020, Det./Cst. Bruce Lake of the H Division Major Crime Unit contacted Cpl. Densmore at his home and requested to interview him. On the same day, C/Supt. Leather and C/Supt. Gray had a phone call with Truro Police Chief MacNeil and Deputy Chief Robert (Rob) Hearn. During the April 24, 2020, teleconference with Truro police executives, the RCMP officers inquired about contacting Cpl. Densmore to arrange an interview with RCMP investigators. The RCMP executives and Truro management who were

on the call were unaware at that time that the RCMP's investigative team had already contacted Cpl. Densmore to arrange an interview.

Chief MacNeil stated that before this telephone call, Truro Police Service (TPS) had received Freedom of Information requests for information related to the perpetrator and understood TPS would thus be required to release the 2011 CISNS bulletin. Chief MacNeil testified that he told the RCMP executives of these events. He told the Commission that C/Supt. Leather and C/Supt. Gray told him that the RCMP wanted to send their investigators to attend the Truro Police Services' offices and examine any records related to the Officer Safety Bulletin. Chief MacNeil stated that he was not comfortable with this proposal:

> [A]nd we had a phone call and the gist of the call was, you know, you're aware of the bulletin. Yeah. You know, this is going to be FOIPOPed? [subject to disclosure pursuant to the *Freedom of Information and Protection of Privacy Act*] Yeah, it is. And it's going to go out? Yeah, it is. And it's potentially going to cause some problems, and I said no, not for us. So anyway, we had that discussion and the RCMP wanted to come and have a look at our records and our holdings and bring in an investigative triangle and all that stuff. So right away, the deputy and I kind of got a little hinky on that and said, no, it's not that's not happening. So I said, listen, why don't you have Janis [Gray] talk to the deputy chief and see what we can do to assist you and we'll send you what we have. You're not coming here to dig into our files and, you know, start to put the magnifying glass on us it was almost felt like. So we both hung up the phone and both the deputy and I both felt like we were we were being we're being nudged in a direction that I wasn't comfortable with and to me it was this bulletin needs to not surface, it needs to we need to explain this bulletin away. Right. And I wasn't interested in doing that. I was very upfront with the RCMP and told them we've got media requests from CBC and from Global and FOIPOP requests and that this is going to be released and part of that and I told them upfront when it was going to be released and all those kind of things.[62]

Regarding the RCMP's request to examine the Truro Police Service's holdings, Chief MacNeil testified that "[w]hen you're dealing with information of source, information of things of that nature, not that this person was a confidential source, but we – you know, you have to protect that information even from other

police agencies."[63] He added, "[W]e just felt that, you know, it might have been an overreach perhaps."[64] In his interview, Chief MacNeil suggested that he felt as though the RCMP was trying to "put a little heat" on the Truro Police to dissuade them from releasing the 2011 CISNS bulletin publicly.

C/Supt. Leather and C/Supt. Gray acknowledged that one purpose of the call was to determine whether there were other records associated with the 2011 CISNS bulletin in the holdings of Truro Police Service. However, C/Supt. Leather denied suggesting, during the April 24, 2020 teleconference, that RCMP investigators attend the Truro Police Service's offices:

> There were no threats to come down there with a tri … with an investigative triangle; that that doesn't even make sense. And no one ever discussed attending their office in that fashion. It's brutish and unprofessional, and it never was discussed in that way.[65]

In his proceedings testimony, C/Supt. Leather reiterated his disagreement with Chief MacNeil's account of the call:

> But back to the conversation with Chief MacNeil, it was nothing more than – it was a very short call and it was more logistics based. But any threat to bring the Command Triangle, to do searches, to look for records in their holdings doesn't even make sense to me in terms of the nature of the conversation that we had with the Chief and the Deputy who was also on the call on the other end, Deputy Hearn was on the call from Truro. And I really don't even know what more to say about that, other than my version of the call is very different than Mr. MacNeil's.[66]

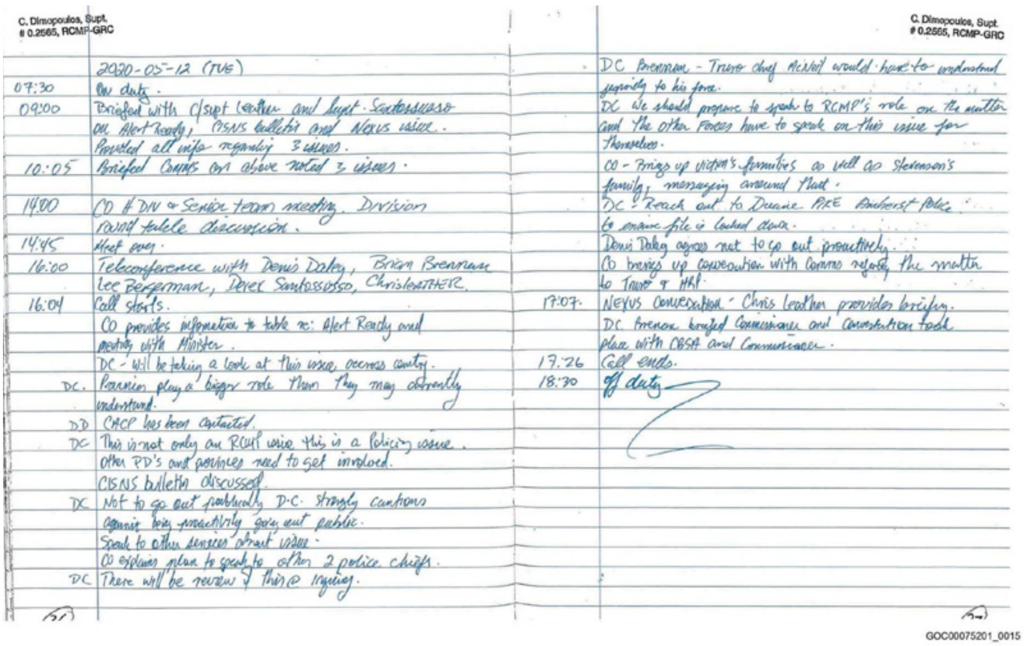
C/Supt. Gray similarly denied suggesting that the RCMP send an investigative command triangle to Truro Police offices.

The disparity between these police leaders' recollections of this call and the overall course of their dealings with one another in this period reflects significant mistrust between Divisional leadership of the RCMP and the leaders of the Truro Police Service. This mistrust prevented them from working productively with one another to understand the events surrounding the 2011 CISNS bulletin. Interagency conflict related to the bulletin persisted after this teleconference. In particular, we note continuing conflict on this issue stemming from an interagency teleconference on May 14, 2020, and related correspondence

between the RCMP and Halifax Regional Police that followed. Before discussing this continuing conflict, however, we address the directions H Division received from national headquarters on May 12, 2020, regarding the disclosure of the 2011 CISNS bulletin publicly.

May 12, 2020, Direction from National Headquarters

On May 12, 2020, H Division executives and Issues Management Team members met via teleconference with national headquarters to discuss, among other topics, whether the RCMP should disclose the 2011 CISNS bulletin to the public. C/Supt. Leather testified that H Division proposed that the RCMP proactively release the bulletin but "it was decided by National Headquarters that that was not a position we were going to be taking."[67] Supt. Dimopoulos similarly recalled that D/Commr. Brennan was strongly of the opinion that the RCMP should not proactively disclose the 2011 CISNS bulletin. His handwritten notes of the meeting state in part:



C. Dimopoulos, Supt.
0.2565, RCMP-GRC

2020-05-12 (TUE)
07:30 On duty.
09:00 Briefed with C/Supt Leather and Supt. Santossusso on Alert Ready, CISNS bulletin and Nexus issue. Provided all info regarding 3 issues.
10:05 Briefed Comms on above noted 3 issues.
14:00 CO & DIV & Senior team meeting. Division round table discussion.
14:45 Meet over.
16:00 Teleconference with Denis Daley, Brian Brennan, Lee Bergerman, Derek Santossusso, Chris LEATHER.
16:04 Call starts.
CO provides information to table re: Alert Ready and meeting with Minister.
DC - Will be taking a look at this issue across country.
DC. Province play a bigger role than they may currently understand.
DD CACP has been contacted.
DC This is not only an RCMP issue this is a Policing issue. Other PD's and provinces need to get involved.
CISNS bulletin discussed.
DC Not to go out publically. D.C. strongly cautions against being proactively going out public.
Speak to other services about issue.
CO explains plan to speak to other 2 police chiefs.
DC There will be review of this @ inquiry.

C. Dimopoulos, Supt
0.2565, RCMP-GRC

DC Brennan - Truro chief McNeil would have to understand [illegible] to his force.
DC We should prepare to speak to RCMP's role on the matter and the other Forces have to speak on this issue for themselves.
CO - Brings up victim's families as well as Stevenson's family, messaging around that.
DC - Reach out to Duane PIKE Amherst Police to ensure file is locked down.
Denis Daley agrees not to go out proactively.
CO brings up conversation with Comms regarding the matter to Truro & HRP.
17:07. NEXUS conversation - Chris Leather provides briefing.
DC Brennan briefed Commissioner and conversation took place with CBSA and Commissioner.
17:26 Call ends.
18:30 Off duty

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Royal Canadian Mounted Police Member's Handwritten Notes (May 12, 2020): COMM0062686 at pp 14–15; Royal Canadian Mounted Police Member's Handwritten Notes, (May 12, 2020): COMM0058648 at pp 10–11

> CISNS bulletin discussed.
>
> [Deputy commissioner] Not to go out publically [*sic*] [Deputy commissioner] strongly cautions against being proactively going out public.
>
> Speak to other services about issue
>
> [Commanding officer] explains plan to speak to other 2 police chiefs
>
> [Deputy commissioner] There will be review of this @ inquiry
>
> [Deputy commissioner] Brennan – Truro Chief MacNeil would have to understand jeopardy to his force
>
> [Deputy commissioner] we should prepare to speak to RCMP's role on the matter and the other forces have to speak on this issue for themselves
>
> [Commanding officer] – Brings up victim's [*sic*] families as well as Stevenson's family, messaging around that.
>
> [Deputy commissioner] – Reach out to Duane [*sic*] Pike Amherst Police to ensure file is locked down
>
> Denis [*sic*] Daley agrees not to go out proactively
>
> [Commanding officer] brings up conversation with Comms referring the matter to Truro + HRP[68]

According to Supt. Constantine (Costa) Dimopoulos, national headquarters did not explain to H Division why they did not want the 2011 CISNS bulletin disclosed:

> COMMISSION COUNSEL: What did they tell you? What did they say to you about why they didn't want it to be proactively disclosed?
>
> SUPT. COSTA DIMOPOULOS: They didn't say much. They indicated on more than one occasion that they didn't want it disclosed. To be quite frank, no real explanation on the merits of not disclosing it was provided, at least that I could recall.[69]

In his testimony before the Commission, D/Commr. Brennan explained his thinking as follows:

> D/Commr. BRIAN BRENNAN: [T]he concern I had was when they spoke about going out with this information publicly, my question was to what end? What are we – what are we trying to articulate to the public about a bulletin that existed? And it wasn't – we weren't the originators of the bulletin, it was a Truro Police Service member and I believe an Amherst Police Service member, and it was a CISNS bulletin. And you know, understanding, again back to my earlier comments, understanding that there is probably going to be an inquiry of some sort around this, this could be a piece of evidence or a document of concern, and are we going out into the – into the, sort of the public domain to try to support a position, are we trying to be forward-leaning for a certain reason?[70]

D/Commr. Brennan acknowledged that members of the public may have wanted to know about the 2011 CISNS bulletin. However, he believed it should not be released until it was requested through a formal process such as a public inquiry:

> We don't, as a practice in policing, provide intelligence or information bulletins like this to the general – to the general public or out in the public forum, they're for police use, and from my point of view, it should remain within the policing realm until such time that's either requested through a process or it's brought forward in evidence or in a environment such as this.[71]

D/Commr. Brennan stated he was unaware of any investigative reason that would require the RCMP to hold back the 2011 CISNS bulletin. That was not the reason he advised against its disclosure.

Supt. Dimopoulos told the Commission that he, Supt. Santosuosso, and C/Supt. Leather disagreed with D/Commr. Brennan about whether to disclose the 2011 CISNS bulletin. They thought the RCMP should proactively disclose it. Supt. Dimopoulos stated that the 2011 CISNS bulletin "had no evidentiary value" to the investigation, and that "in my mind, there was no reason to hold back this piece of information from the public."[72] However, Supt. Dimopoulos did not voice that opinion during the call with national headquarters. He explained to the Commission that H Division was required to follow national headquarters' direction on this:

> Well look, the direction. It was clear from the Centre from Deputy Brennan and Mr. Daley. Whether I agree with it or not, is secondary. I mean, they have to answer to that. I can speak to what I did with regard to

> pushing issues forward that should be disclosed, but everybody has, you know, everybody has to follow direction in the end, whether you agree with it or not, as long as it's lawful.[73]

In Chapter 10 of this volume, we supply a longer discussion of RCMP management culture, including past reviews that have suggested that RCMP's paramilitary culture deters robust discussion of issues about which there may be disagreement.

May 14, 2020, Teleconference and Related Correspondence

Two days after the May 12, 2020, call with national headquarters, H Division invited Amherst Police Department, Truro Police Service, and Halifax Regional Police leadership to participate in a teleconference with H Division executives and Issues Management Team members regarding the 2011 CISNS bulletin. In attendance from the RCMP were C/Supt. Leather, C/Supt. Gray, Supt. Dimopoulos, Supt. Santosuosso, and Supt. Darren Campbell. The municipal police representatives who attended the meeting were Chief David MacNeil and Deputy Chief Robert (Rob) Hearn of Truro Police Service, Deputy Chief Don MacLean of Halifax Regional Police, and Chief Dwayne Pike from Amherst Police Department. The meeting's agenda, prepared by the RCMP, identified the topic as "Issues Management – CISNS Bulletin." According to the meeting's minutes, C/Supt. Leather outlined information about the involvement of each of the four police agencies with respect to the 2011 CISNS bulletin. C/Supt. Leather also outlined the RCMP's next steps, which are recorded within the meeting minutes, in part as follows:

> - RCMP Next Steps
>   - Our next step as it relates to the RCMP and this matter is that we have initiated an Issues Management Team as I mentioned earlier, and which will deal with issues such as this and there are many others.
>   - As a commitment to the other services here on the line, I will [be] providing, or the Division will be providing, what we know to date and which is what I read off, but also the times [*sic*] lines from the 2011 timeline, and then as best we can establish them. The second

> time line – the bulletin being discovered, forwarded and brought to our attention.
>
> ◇ An overview of what we know to date and timelines to be distributed to call attendees in the coming days.[74]

C/Supt. Leather and Supt. Campbell told the municipal chiefs that the RCMP would not be disclosing the 2011 CISNS bulletin publicly because it was related to ongoing criminal firearms investigations; however, the RCMP was "in the throes of actively creating reactive media lines, should the bulletin, or existence of the bulletin should it be leaked."[75] As noted, C/Supt. Leather acknowledged in his Commission interview that the decision not to disclose the 2011 CISNS bulletin was actually made by national headquarters. H Division had proposed to national headquarters that it be proactively disclosed. As D/Commr. Brennan testified, national headquarters' decision against disclosing the 2011 CISNS bulletin was not based on any concerns about investigative integrity. Supt. Campbell, however, testified that there were investigative reasons not to disclose it:

> COMMISSION COUNSEL: But the bulletin was nine years old at that point, so why would releasing a nine year old bulletin compromise the investigation in 2020?
>
> SUPT. DARREN CAMPBELL: Well, it might speak to how long we might have to go back in terms of our inquiries or, you know, who might have had awareness or knowledge. So you know, as an investigation unfolds there's a lot of unknowns and you don't know what steps that you might take that could be a benefit or they could be negative. There's a lot of "what ifs" within that environment.[76]

We find on the basis of the evidence given by C/Supt. Leather, Supt. Dimopoulos, and D/Commr. Brennan that investigative integrity was not the reason why the RCMP wished to hold back public disclosure of the 2011 CISNS bulletin. We return to the question of police investigative independence and its tensions with democratic accountability in Part C of this volume. For present purposes, we note that the disagreement among RCMP leaders over whether there could have been an investigative justification for holding back this information demonstrates that the parameters of investigative considerations may be the subject of reasonable disagreement, even among police. As this example suggests, claims about the application of investigative justifications for withholding information from the public sometimes warrant closer analysis.

C/Supt. Leather told the Commission that although the RCMP had no immediate plans to release the 2011 CISNS bulletin publicly, he explained to the chiefs that the RCMP would collaborate with municipal police on messaging when the RCMP did decide to release it:

> [I]t's not like when the meeting's over, we're rushing out the door to put this out with whatever message we were going to put out to the public, that it was a commitment to them that before we did that, I would want to be collaborating with them and even look for their input and a joint message. That's where I was going with those comments. And as you say then Dave MacNeil came in with his FOIPOP comments.[77]

Chief MacNeil reiterated during the May 14, 2020, teleconference that Truro Police had already received a Freedom of Information and Protection of Privacy (FOIPOP) request from the CBC for information about the perpetrator.

On May 26, 2020, C/Supt. Leather followed up with the chiefs of Amherst, Truro, and Halifax Regional Police. He provided the chiefs with a summary of his speaking points from the May 14 2020, teleconference, along with a document titled, "'H' Division Issues Management Team (IMT) Officer Safety Bulletin" (the Issues Management Team Report). That report identifies Amherst, Truro, Halifax Regional Police, the RCMP, and Criminal Intelligence Service Nova Scotia as the "Involved Police Services" and outlines information about their role with respect to the 2011 CISNS bulletin. The final section of the report, "Current Status," identifies five issues: bulletin retention, CISNS policy, strategic communications, the public inquiry, and dissemination of the bulletin.[78] Under the heading "Strategic Communications," the report reiterates the RCMP's intention to create "reactive media lines, should the bulletin, or existence of the bulletin be leaked."[79]

The May 14, 2020, teleconference and the related Issues Management Team Report were poorly received by some municipal police leaders. Over the next few days, C/Supt. Leather and Chief Kinsella exchanged a series of emails about the RCMP's treatment of the 2011 CISNS bulletin. On May 27, 2020, Chief Kinsella emailed H Division and municipal police executives with concerns that the Issues Management Team Report seemed to focus on the actions of municipal agencies but did not "provide a similar level of detail about what the RCMP did or did not do in relation to the follow up requested of RCMP in the 2010 investigation and then again on requested follow up in regards to the OSB [Officer Safety Bulletin] in 2011." He asked the RCMP to clarify the purpose of, and the audience for, the report and to

identify the members of the Issues Management Team. The email stated in closing, "We should [be] mindful of any upcoming processes, the need for accuracy and our respective responsibilities not to speak for each other."[80]

On May 29, 2020, C/Supt. Leather replied to Chief Kinsella's email, copying the other municipal chiefs. He stated that the purpose of the Issues Management Team Report "was to honour my commitment and to provide to everyone in attendance [at the May 14, 2020, teleconference] an overview of the bullet points referred to on page 3 of the report," adding, "[T]his was clearly articulated during the [teleconference]."[81] C/Supt. Leather addressed Chief Kinsella's question about the purpose of the Issues Management Team as follows:

> The purpose of the Issues Management Team was fully explained at the TC [teleconference] to all in attendance. Regardless, it was stood up to run parallel to the investigative team, and reports directly to my office. Its mandate and structure is well defined and has been stood up by two senior RCMP Superintendents from outside of NS, who are very experienced with multiple homicide investigations, and who have an understanding and experience in the Inquiry Process, and external Labour Code Reviews.
>
> The team's mandate is strictly limited to dealing with RCMP related issues. It is compiling searchable, and evidence based information, which will be made available to whatever review process is mandated by government, and of course RCMP counsel.[82]

Regarding Chief Kinsella's statement that the report omitted information about the RCMP's involvement in the 2010 and 2011 files related to the perpetrator, C/Supt. Leather stated:

> As for the actions of the RCMP, the narrative of our actions is fully outlined in the holdings of the HRP VERSADEX [software] file. We have no detailed narrative in our PROS system [Police Reporting and Occurrence System], as the original RCMP file was an assistance file and as per RCMP policy has since been purged, and I saw no point in providing details back to HRP that you already have in your holdings. The actions of the RCMP are also provided with sufficient detail in the time line chart, and accurately reflect our actions vis a vis the bulletin only.[83]

On June 2, 2020, Chief Kinsella replied to C/Supt. Leather. He reiterated his concern about the absence of information in the Issues Management Team's report regarding what the RCMP did after they received information about the 2010 threats and the 2011 CISNS bulletin:

> While I am concerned about the gaps and inconsistencies in the documents provided, my bigger concern is that while the memo goes into great detail about your view on what other Services did or did not do after receiving the CISNS [Criminal Intelligence Service Nova Scotia] memo, it is silent about any subsequent action by the RCMP, the fundamental issue of what RCMP did once the information about the 2010 threats and then the 2011 OSB [Officer Safety Bulletin] were passed to RCMP from HRP [Halifax Regional Police] is missing. If you don't know because you have purged files, then it should be included in the document. To say that the "the narrative of our actions is fully outlined in the holdings of the HRP VERSADEX file" is misleading. We did not hear back on what those actions were, so they could not be fully outlined in HRP reports.
>
> So I have a concern about the overall premise on how the note was written. After the information was provided to RCMP, it was no longer an assistance file and nothing in the IMT [Issues Management Team] speaks to the issues of what was done with the information HRP provided to RCMP.
>
> Fundamentally, it is important to be accurate in the documentation. As HRP is one of agencies being written about in the note, that accurate representation is a critical point for me.[84]

On June 2, 2020, C/Supt. Leather provided a further reply, stating in part, "In the interest of stating factual information, only information which could be sourced back to a valid reference was included"; and, "Since the RCMP's files on these matters were purged, as per our policy, we were unable to say what did or did not occur, and therefore relied on what was documented by HRP on your 2010 file." His email stated further, "On its face, the actions taken by HRP in 2011 appear to be more than an assistance file," noting that "Independent investigative steps in trying to verify the source of the information, speaking to [the perpetrator's] father, and going to [the perpetrator's] Dartmouth address were taken by HRP before contacting the Bible Hill Detachment."[85] C/Supt. Leather stated, "What occurred

next is in question, as the RCMP files have been purged and there are no further entries on the HRP Versadex file"; and, "Therefore, neither agency can definitively say what next steps were, or were not taken." The email included an offer to discuss the issue further in person. It also suggested that HRP should consider providing the RCMP with "a detailed summary and timeline" of its involvement with the perpetrator, which C/Supt. Leather "underst[ood] began in the nineties, and ended this year."[86]

Chief Kinsella replied the following day on June 3, 2020, stating that he could not support the Issues Management Team Report "and the way it represents information about HRP":

> [J]ust to reiterate HRP has captured all interactions with [the perpetrator] and the appropriate conclusions to each of those interactions. What is not captured anywhere is what if any follow up [RCMP Cst.] Greg Wiley did in 2010 or [RCMP Cst.] John McMinn did in in 2011 in Bible Hill with the information that guns were allegedly illegally stored at [the perpetrator's] Portapique address. The only thing we know is Wiley was friends with [the perpetrator] and had not seen guns. I believe we have now gone over all the points and I cannot support this IMT and the way it is presented and the way it represents information about HRP … As I have said before, with the potential of a public inquiry, we have to be careful about avoiding misrepresentation and ensure we are not speaking on behalf of one another.[87]

Chief Kinsella addressed this email exchange in his written evidence as follows:

> As to the second question, regarding the exchange with C/Supt. Leather, much like the Alert ready discussions, it appeared that it was an attempt to generate a narrative around fault-finding in other agencies by the RCMP rather than focusing on what reasons may have led to the information in the CISNS bulletin not being utilized or acted upon in the first place by RCMP.[88]

Chief MacNeil shared Chief Kinsella's concerns about the Issues Management Team Report. He testified that, in his view, the document explained the role of Amherst, Truro and, Halifax Regional Police in relation to the 2011 CISNS bulletin but did not adequately explain what the RCMP did, or should have done, to follow up on the

matter. Chief MacNeil explained that that the May 14, 2020, teleconference and Issues Management Team Report distributed afterward left him with the impression that the RCMP was trying to control the public narrative about the 2011 CISNS bulletin and shift blame onto other police agencies:

> So I think they realized that it was going to get out and then it shifted from that to OK, justifying the bulletin. And so during this whole process, they brought in people from Ottawa, superintendents, and they were called the Issues Management Team. And that really offended me, too, that they took this tragedy and defined it as an issue … There's a document I believe I shared with you the H Division Issues Management Team, Officer Safety Bulletin. They had a whole package done on this. And Amherst Police Chief Pike, myself, and Chief Kinsella from Halifax were brought into this because all our officers, all our agencies were somewhat involved. Halifax because the guy's address was Dartmouth, us because we created the bulletin, and Amherst because they still had the bulletin. And it all became to me about a blame game. A, like what did you do, Truro, to investigate this? And I'm thinking, no, no, you're not going down this road with me. And then Dan Kinsella, what did Halifax do? What did you guys do? And then Amherst, how did you have this bulletin? And why is it still alive? Right. And it became very clear the three chiefs talked afterwards, it became very clear that this is how do I take this bull's eye and put it on all the three agencies … So that's the bulletin. It became a real issue, a contentious issue. I felt as if, I'm not going to say pressured, but I felt I felt as if the bulletin could go away they would be very happy. And I wasn't about to do that because that's not the way I do business. And it became an issue for sure.[89]

Chief Pike explained that he did not attend the entire call on May 14, 2020, but his impression was that there was "a lot of concern" from the RCMP about why Amherst had retained a copy of the 2011 CISNS bulletin and the potential for the bulletin to become public:

> I didn't realize it was such a huge issue until at one point I got called to jump in on a really quick Zoom meeting in regards to the bulletin. And some of the questions were like, "Well, why … why do you guys still have that bulletin?" So, it was just in the guy's email. We just, you know … "Well, what's your policy in regards to retention?" I said, "Well, for emails and

> stuff, we don't really have a policy. It just depends on, you know, sooner or later, you have to delete emails to make room." But it just seemed like there was a lot of concern there.[90]

He stated that "the feeling [he] got, was that there was some concern" from the RCMP about the 2011 CISNS bulletin being made public:

> COMMISSION INVESTIGATOR: So, did you sense that the RCMP had concerns about this bulletin being made public, or?
>
> DWAYNE PIKE: That's ... that's the feeling I got, was that there was some concern. And again, I was kind of like ... I didn't realize it was an issue until all of a sudden, there's a lot of conversation about this. "Where'd this come from?" and "Where did you guys get this?" And then I realized that, oh-oh, this is ... this is something that's going to be an issue for them kind of thing, right. Again, I wasn't familiar with a lot of the background in regards to what work was done on it back when the bulletin initially came out. I was just aware that we had a copy of a bulletin that dealt with a person that, you know, lived in Halifax but had a ... you know, a cottage in Portapique and that was it. And I really ... up until, you know, it kind of worked its way up through the management of the RCMP, I really had no idea, you know, how significant of an issue it was going to be.[91]

C/Supt. Leather testified that, despite the impression of some of the municipal chiefs, the RCMP's intention was not to "blame or shift the responsibility to them."[92] Rather, the May 14, 2020, call was "an effort to discuss and to look for a communication strategy coming out of [the 2011 CISNS bulletin], should the other Chiefs want to participate."[93] Further, C/Supt. Leather testified that the Issues Management Team Report was an effort by the RCMP to be "transparent with the Chiefs of Police" regarding the "investigation of the existence of the Bulletin and which agencies were impacted by it." In his view, the RCMP's actions in this call and the April 30, 2020, teleconference about Alert Ready (addressed above) were "twisted to be something they were not."[94]

Supt. Dimopoulos stated that although the RCMP's decision was not to disclose the 2011 CISNS bulletin at that time, they wanted input from the other police agencies about how to address it going forward. He told the Commission, "I'm a firm believer in ... in speaking with one voice and in the policing community"; and "the whole purpose of that meeting was to provide information to the participants so

that we can make a decision and move forward on it."[95] However, Supt. Dimopoulos described perceptible tension during the May 14, 2020, teleconference. Supt. Dimopoulos attributed this tension, at least in part, to underlying problems related to the relationships between the RCMP on the one hand and Truro Police Service and Halifax Regional Police, on the other. He explained that the May 14, 2020, teleconference was part of a pattern of difficult communications among the RCMP, Halifax Regional Police, and Truro Police Service. Supt. Dimopoulos also took exception to Chief MacNeil's perception that the Issues Management Team were "fixers from Ottawa." He stated, "[W]e're not the boogeymen from Ottawa. Like, we're there to do a job. We're there to speak to issues and bring them to the forefront and share the information when possible."[96] Supt. Dimopoulos opined that Chief MacNeil's impression of the Issues Management Team "speaks to the relationship" between the RCMP and Truro Police, and "preconceived notions that the chief may have."[97]

Chief Kinsella, Chief MacNeil, and Chief Pike all expressed their view that the RCMP were concerned about the 2011 CISNS bulletin being made public. Chief Kinsella specifically had an impression that, after the mass casualty, H Division was attempting to shift blame related to the 2011 CISNS bulletin away from the RCMP and onto municipal police. Learning that an RCMP Issues Management Team led by out-of-province RCMP officers was compiling information about municipal agencies' involvement in previous investigations of the perpetrator in anticipation of developing a communications and media strategy and preparing for a potential inquiry created unease among the involved municipal police. However, as both C/Supt. Leather and Supt. Dimopoulos suggest, the lack of interagency collaboration after the mass casualty also related to deeper problems of mistrust between the agencies. C/Supt. Leather acknowledged it was "an uphill battle from the start" in terms of the agencies' ability to work productively together on this and other issues.

Supt. Dimopoulos acknowledged in his interview with the Commission that the 2011 CISNS bulletin raised larger questions about information sharing and retention among police agencies which required collective review by law enforcement partners:

> COMMISSION COUNSEL: But if I understood your earlier evidence correctly, you would say, wouldn't you, that this is something the RCMP should itself look at, as opposed to waiting for some external body, whether it be a court or this Commission to look at.

> SUPT. COSTA DIMOPOULOS: Absolutely. I agree that the RCMP has to look at the big picture with regard to the event and what happened. There has to be a significant frame of reference and this issue here with regard to the CISNS bulletin is but one component of many that a larger review should look at. This particular issue, again, needs to be looked at collaboratively with the stakeholders. It's not just an RCMP issue; it's part of a larger conversation surrounding Memorandums of Understanding with regard to how information and intelligence is shared, how data is stored, where, you know, how notes and records are kept. It's part of a larger accountability exercise. This is not a one-off in my mind. I would argue there's probably a lot more of these out there that are probably sitting in somebody's desk.[98]

MAIN FINDING

There were several barriers to an effective interagency review of gaps in information sharing and co-ordination in relation to the 2011 Criminal Intelligence Service NS bulletin about the perpetrator. One of those barriers is that the RCMP's Issues Management Team assigned to address the bulletin was not focused on examining it with a view to institutional learning, and there was no other team within the RCMP carrying out that work. A second barrier was the interagency conflict and distrust that prevented involved police agencies from working co-operatively to examine lessons learned arising from the bulletin. A third was the position taken by the RCMP that the bulletin should not be proactively disclosed to the public, which further elevated the mistrust of municipal police leaders.

The RCMP's failure to grapple with the implications of the 2011 Criminal Intelligence Service NS bulletin represented another missed opportunity to learn the lessons that emerged from the mass casualty. The RCMP's decision not to proactively disclose information about the bulletin was not taken for investigative reasons, and this decision increased public and peer mistrust of the organization. The collective failure of Nova Scotia police leaders, including H Division officers, to constructively address the conflict that arose among them in the aftermath of the mass casualty only exacerbated these concerns.

LESSON LEARNED

An incident such as a mass casualty should prompt good faith collaboration by police agencies to examine whether gaps in interagency information sharing or coordination affected prior police responses to the perpetrator.

Conclusion

In this chapter, we have evaluated the genesis and work of H Division's Issues Management Team, which was established after the mass casualty to serve a number of purposes, including analyzing issues of divisional and national significance, assisting with internal and public communications, and preparing for an anticipated public inquiry. We have documented and assessed the RCMP's work on two issues that attracted considerable public interest after the mass casualty: the potential of the Alert Ready system to provide public warnings during a mass casualty; and the police response to a 2011 Officer Safety Bulletin issued by the Criminal Intelligence Service Nova Scotia. The RCMP's handling of these two issues went beyond the Issues Management Team, engaging national headquarters and, in the case of Alert Ready, external consultants. These issues also went beyond the RCMP, engaging other municipal police agencies in Nova Scotia. Disagreement about whether and how to communicate publicly about these issues had a significant impact on relations between H Division leaders and some municipal police chiefs, further eroding their willingness to work together.

The RCMP's handling of the Alert Ready issue and 2011 CISNS bulletin reflected the lack of institutional attention to self-evaluation that we have also documented in earlier chapters in this Part. The Issues Management Team was not tasked with assessing the RCMP's handling of these issues, nor was that responsibility assigned elsewhere in the organization. A great deal of the RCMP's institutional time and attention was dedicated to identifying the risks associated with sending a public alert and documenting the role played by other municipal police agencies in the 2011 CISNS bulletin. Staff at national headquarters were engaged with these issues and, in some instances, directing H Division with respect to them.

Finally, the disagreement between the province and the RCMP concerning funding of the Issues Management Team provides a glimpse of some of the challenges that arise in provincial / RCMP relations regarding contract policing and, in particular, with respect to the province's capacity to manage the costs of RCMP policing. Despite the Nova Scotia minister's position that Nova Scotia should not pay for what he regarded as an exercise that served the interests of national RCMP rather than those of Nova Scotia, the Issues Management Team (and, later, H-Strong II) was convened and Nova Scotia funded a portion of its work. We return to the challenges of provincial / RCMP relations in contract policing, in Part C of this volume.

In the next, and last, chapter of this Part on the continuing crisis, we turn to the role played by Nova Scotia's Serious Incident Response Team (SiRT) in the aftermath of the mass casualty.

CHAPTER 8

Involvement of the Serious Incident Response Team in the Post-Crisis Period

CHAPTER 8 Involvement of the Serious Incident Response Team in the Post-Crisis Period

This chapter explores the work of the Nova Scotia Serious Incident Response Team (SiRT) and its interactions with RCMP H Division members and members of some of the affected communities in the months after the mass casualty. **The Serious Incident Response Team was established by amendment to the *Police Act* in 2010, and became operational in 2012. It is responsible for investigating serious incidents involving police in Nova Scotia. The *Police Act* defines "serious incident" as one involving "death, serious injury or sexual assault or any matter that is determined under this Act to be in the public interest to be investigated."**[1] **The SiRT was established to ensure these incidents are investigated by a body that operates independently from police agencies.** The SiRT's task in investigating serious incidents involving police is narrow. It determines only whether criminal charges are warranted against the subject police officer(s). The SiRT does not consider whether a police officer's actions otherwise violate standards of professional conduct. The SiRT director is responsible to the Nova Scotia minister of justice for "the direction of investigations and reporting on serious incidents involving police," among other duties.[2]

The SiRT conducted two investigations in relation to the RCMP's response to the mass casualty: one into the shooting at the Onslow Belmont Fire Brigade hall (referred to as the "Onslow fire hall shooting") on April 19, 2020, and one into the shooting of the perpetrator at the Enfield Big Stop gas station on April 19, 2020. In both investigations, the SiRT determined that no criminal charges were warranted against the involved RCMP members. **Pursuant to clause (g)(i) of the Orders in Council establishing this Commission, we must perform our duties "without expressing any conclusion or recommendation regarding the civil or criminal liability of any person or organization." Consistent with this limitation, we do not evaluate the SiRT's conclusions about whether charges were warranted against any police officer.**

The issues addressed in this chapter include the relationship between RCMP H Division and the SiRT. In particular, we consider the SiRT's reliance on H Division for specialized services and technical assistance, and protocols for communications and information exchange between H Division and the SiRT relating to the SiRT's investigations of RCMP members. We also identify that uncertainty arose after the mass casualty regarding the provision of victim support or mental health services to individuals affected by serious incidents involving police. Drawing on Ontario's 2017 Independent Police Oversight Review (the "Tulloch Report") led by the Honourable Michael H. Tulloch, now Chief Justice of Ontario, we discuss the SiRT's public accountability function and examine whether the reports presently published by the SiRT adequately discharge this function. In the final section of this chapter, we address evidence we received about a SiRT referral made by the RCMP in July 2020, which alleged criminal conduct by members of a municipal police service unrelated to the events of April 18 and 19, 2020 (the "July 2020 Referral"). In particular, we discuss whether evidence of a conflict between police agencies influenced the decision not to invoke the SiRT's mandate in that case, and address steps taken by the RCMP and the SiRT after the SiRT declined to proceed with a criminal investigation.

The SiRT's Jurisdiction in Relation to the RCMP

The SiRT is distinct from other Nova Scotia police oversight bodies because it has jurisdiction to investigate members of both the RCMP and municipal police. By contrast, Nova Scotia's Office of the Police Complaints Commissioner (OPCC) has jurisdiction only in relation to municipal police officers. The OPCC has no jurisdiction to investigate or review actions of RCMP members. This is because the OPCC deals with complaints of police misconduct under the *Police Act*, whereas the SiRT is responsible for investigation of potential crimes. The Supreme Court of Canada has held as a constitutional principle that the provinces are empowered to investigate alleged crimes by RCMP members but have no jurisdiction to oversee disciplinary or misconduct matters in relation to RCMP members. In Part C of this volume, we discuss in more detail the patchwork system of police oversight that

this principle generates. For present purposes, the key point is that the SiRT has jurisdiction to investigate serious incidents involving RCMP members because the Supreme Court of Canada has held that RCMP members "enjoy no immunity from the criminal law and the jurisdiction of the proper provincial authorities to investigate and prosecute criminal acts committed by any of them as by any other person."[3]

The SiRT's Resources

The SiRT is a team of six people. This includes the civilian director, four investigators, and one administrative assistant. Of the four investigators, two are retired RCMP members and two are seconded police officers (one from the RCMP and one from Halifax Regional Police [HRP]). The *Police Act* does not prohibit a current police officer who is seconded to the SiRT from investigating members from their home agency. However, they cannot be the team commander or lead investigator in such an investigation. The SiRT investigators who are *retired* from the RCMP can and do lead investigations of serious incidents involving RCMP members. However, the Commission heard evidence that as a matter of practice, SiRT investigators who are retired from the RCMP may choose to recuse themselves from investigations where the subject officer is an RCMP member whom the investigator previously supervised.

The SiRT does not have its own specialized investigative resources such as a Forensic Identification Services (FIS) team. Rather, the SiRT enters into agreements with police agencies for the use of their specialized teams when those services are required.

The SiRT Use of RCMP Forensic Identification Services

In Chapter 6 of Volume 2, What Happened, we address the shooting of the perpetrator by RCMP members at the Enfield Big Stop gas station on April 19, 2020. At about 11:50 am on April 19, 2020, RCMP Insp. Rob Bell reported the shooting to SiRT investigator Keith Stothart. Insp. Bell advised that a male subject had been shot and killed by police, but he was uncertain at that time whether the shots were discharged by RCMP or Halifax Regional Police Emergency Response Team (ERT) members. Investigator Stothart and Insp. Bell discussed the deployment of Forensic Identification Services (FIS) to the scene of the shooting and "it was decided HRP FIS [would] be called out due to the RCMP having multiple crime scenes to process."[4] However, a later email from HRP S/Sgt. Donald (Don) Stienburg explains that while HRP FIS members were on their way to the Enfield Big Stop scene, they were "called off by SiRT" because "RCMP Ident [RCMP Identification Services] were able to do the scene."[5] A note by S/Sgt. Stienburg dated April 27, 2020, offers further details:

> I called SIRT investigator Keith Stothart. SIRT Director Pat Curran call[ed] me later after Keith Stothart became involved. Director Curran was aware Keith Stothart was investigating. Keith had spoke to Insp Rob Bell (RCMP) And he was requesting HRP Identification Services process the scene. I call out Sgt Habib and had the command bus sent [to] the Big Stop. Later I discovered RCMP Identification Services were available and were processing the scene. This would be normal procedure where the incident happened in [an] RCMP patrolled area of Halifax Regional Municipality. The idea was they might be too busy but they decided they could do this scene on the way up to Portapique. After discussion with Keith Stothart I called off HRP Identification Services.[6]

HRP duty officer Insp. Derrick Boyd's notes state that when he attended the Enfield Big Stop scene at 12:30 pm, "RCMP Ident was on scene" and "Keith [Stothart] wanted RCMP Ident to continue with the scene."[7] C/Supt. Christopher (Chris) Leather told the Commission that the SiRT requested the use of the RCMP's FIS via a phone call to H Division Support Services on April 19, and the RCMP "provided that assistance."

The respective responsibilities of the SiRT and the RCMP at the scene of a serious incident involving RCMP members are found across several legal and policy instruments including the *Serious Incident Response Team Regulations* (the "*SiRT Regulations*"), the memorandum of understanding between the SiRT and H Division, and RCMP policy. The *SiRT Regulations* require the chief officer of the subject police agency to "ensure that the chief officer's agency secures the scene in a manner consistent with the policies and usual practice of that agency."[8] Chapter 54.1 of the *H Division Operational Manual* contains a similar requirement. It states that "[p]rior to SiRT's arrival, the RCMP will maintain custody of the scene and take all lawful measures to preserve evidence related to the matter."[9] According to the memorandum of understanding between the SiRT and H Division, the responsibility to secure the scene pending the SiRT's arrival may include, among other activities, "Forensic Identification Services including evidence collection, processing, and analysis."[10] However, the former SiRT director, retired Supreme Court of Nova Scotia justice Felix Cacchione, told the Commission that, in his understanding, the subject police agency's role in securing the scene of a serious incident was essentially to keep it intact until the SiRT arrived. He did not recall the practice of "the RCMP collecting evidence before [the SiRT] were on scene."

The memorandum of understanding states further:

> When an RCMP member is the subject of an investigation, it is understood certain resources may be most appropriately provided by RCMP. In particular, specialized units such as Forensic Crime Scene Investigation Units are most effective when operating in their own jurisdiction and at the immediate outset of an investigation. In addition it may be very difficult for such units from outside agencies to effectively travel to other scenes. In cases where such units are utilized, they would operate under the direction of SIRT and an investigator may be assigned to observe their investigations where necessary to assure independence.[11]

The memorandum of understanding also states that "Requests for RCMP resources will be made by the Director of SIRT or designate to the OIC [officer in chief] Criminal Operations or delegate."[12]

Chapter 54.1 of the national *RCMP Operational Manual* addresses the circumstance in which specialized RCMP resources are required by a provincial investigative body that is empowered to investigate a serious incident. The policy provides that in this instance, a designated RCMP member will coordinate the provision of those

resources and "ensure that any specialized resources are screened for any actual or perceived conflict of interest using the criteria outlined on Form 6402."[13]

C/Supt. Janis Gray told the Commission that "it is often the case that RCMP forensic officers provide support to SiRT and other external investigative bodies," including when RCMP members are the subject of the investigation. She stated that she could not speak to whether it was consistent with best practices for the RCMP to carry out forensic identification work in a SiRT investigation of RCMP members. However, in her view, "a SiRT investigation is more about the police officer that's being investigated as opposed to the RCMP being investigated." C/Supt. Gray also emphasized her confidence in the impartiality of RCMP forensics officers.[14]

Other witnesses acknowledged that it would be preferable for the SiRT to avoid using investigative resources from the police agency of the officers under investigation. Director Cacchione told the Commission that he preferred that the RCMP FIS not be used in SiRT investigations of RCMP members, even if it is the closest FIS unit. He stated, "[C]ertainly, in today's society with conspiracy theorists abounding, it would be preferable that another agency look at conducting that portion of the investigation."[15] Patrick (Pat) Curran, former SiRT interim director and retired chief judge of the Provincial Court of Nova Scotia, also acknowledged that using FIS resources from the police agency under investigation "could and certainly might appear to" affect the independence of the SiRT.

C/Supt. Leather also acknowledged the potential for a conflict of interest when RCMP resources are employed in SiRT investigations of RCMP members. He explained that the use of RCMP specialized services in these investigations is "not a perfect situation by any stretch," but it is a reality given the SiRT's limited resources. C/Supt. Leather stated that he would like the SiRT to have its own specialized resources because "[i]t would then have its complete independence." However, "[t]he reality of the situation is [the SiRT] [does not] have those capabilities here given the size of the unit and so, they have to call upon [the RCMP] for assistance."[16] Like C/Supt. Gray, C/Supt. Leather emphasized his confidence in the impartiality of RCMP Support Services members, including FIS members.

Interim Director Curran stated that there would be advantages to the SiRT having its own forensic identification services team, but added that "SiRT, on a daily basis, doesn't have need of an FIS team" and "you'd have people that a lot of times would be looking for something to do."[17] He was "not sure that [an independent SiRT FIS team] would make enough difference in relation to the independence or more likely the perceived independence of the [SiRT] to warrant the expense in a small place."[18]

Interim SiRT director Pat Curran was the acting director of the SiRT in April 2020. He stated that he could not recall exactly when he became aware that the RCMP Forensic Identification Services team had processed the Enfield Big Stop scene. However, by the time he became aware, it was too late for him to express concerns about that decision. He explained that, in any case, he did not have concerns about the SiRT's use of RCMP FIS in this investigation because the "basic facts" such as "who was shot [and] who did the shooting" were not contentious.[19] While he could conceive of other situations where he would have been concerned about which agency processed the scene, this was not one of those cases.

In Volume 3, Violence, we drew on the expert report prepared by academic psychologists Dr. Kristy Martire of the University of New South Wales and Dr. Tess Neal of Arizona State University to define bias as "any systematic factor that might affect the outcome of an assessment other than the truth."[20] Dr. Martire explained in testimony that in this sense, bias is "not a reflection of unprofessional conduct or poor training," but psychologists who study bias "would want to see that [the risk of bias] has been acknowledged and steps have been taken to try and mitigate or manage those biasing factors."[21] **There is now an extensive body of research that shows that bias may be a serious issue in forensic science when forensic identification specialists are exposed to information that may unconsciously bias their work. This tendency is not a reflection of unprofessionalism or unethical behaviour; rather it is a product of universal human cognitive traits. The only way to mitigate unconscious bias is by adopting measures that protect forensic specialists from information that has the potential to bias their conclusions, before and during the time when they are doing their work.** In short, we concluded in Volume 3, Violence, that the potential for bias – and the responsibility to mitigate against it – are matters of institutional process and design, not an individual failing. Dr. Martire and Dr. Neal identified the existence of an employment relationship between a forensic specialist and the subject of their work as a potential source of bias.

The decision to use the RCMP's forensic identification services to process the Enfield Big Stop scene gave rise to a risk of unconscious bias. In circumstances where an alternative service was available, it was unnecessary for SiRT to take this risk. The decision to use RCMP Forensic Identification Services also increased the risk that the public would perceive the SiRT process of investigating RCMP members as lacking independence from the RCMP.

MAIN FINDING

In the particular circumstances of the investigation at the Enfield Big Stop, in which specialized forensic investigation services were available from the RCMP and from Halifax Regional Police, the Serious Incident Response Team should have taken immediate steps to ascertain which police agency's members were involved in shooting the perpetrator, and engaged the forensic identification services of the other agency.

LESSON LEARNED

The Serious Incident Response Team performs a crucial role in safeguarding public trust in the police and the overall fairness of the Nova Scotia criminal justice system. It is imperative that their work be – and be seen by the public to be – independent of the police agencies whose members they investigate.

Recommendation P.27

SERIOUS INCIDENT RESPONSE TEAM INVESTIGATORS AND SPECIALIZED SERVICES

The Commission recommends that

Whenever feasible, the Serious Incident Response Team (SiRT) should perform its work using investigators and specialized services from an agency separate from the one that employs the officer who is the subject of the investigation. If this is not feasible, the decision to use investigators or specialized services from the police agency that employs the subject officer should be made by the SiRT's civilian director. In writing, and at the time when the decision is made, the SiRT director should document the reasons why using resources from the agency that employs the subject officer is necessary.

A Note on Decision-Making Authority at the Scene of a Serious Incident Involving Police

Before concluding this section, we highlight an uncertainty arising in H Division's policy regarding the respective decision-making authority of the SiRT and the RCMP at the scene of a serious incident involving RCMP members. The memorandum of understanding between the SiRT and H Division recognizes that "[w]hen SIRT assumes responsibility for the investigation, SIRT will immediately assume command of all activities related to the investigation and direct resources accordingly." Former SiRT director Felix Cacchione explained that, consistent with this provision, the SiRT has exclusive control over investigations of serious incidents involving police:

> Once [the SiRT] take[s] on the referral and begin[s] the investigation it's our investigation and our investigators direct the RCMP, Halifax Police, Cape Breton Police, Stellarton Police as to what they should do and what is required. So, we are in control of the investigation, the investigator; when I use "we," it's the investigator. So it's no longer an RCMP investigation; it's a SiRT investigation.[22]

However, Chapter 54.1 of the *H Division Operational Manual* contemplates that in situations where the RCMP conducts a "statutory investigation" concurrently to a SiRT investigation of RCMP members, the decision-making authority regarding who takes custody of the scene and exhibits is shared between the two agencies. The term "statutory investigation" is not defined. The H Division Operational Manual states:

> 2.5.1 The RCMP will be required to continue the pre-existing statutory investigation of the initial incident, when it occurs within RCMP jurisdiction.
>
> ...
>
> 2.6.1 Upon SiRT's arrival, the primary SiRT and primary RCMP investigators will jointly determine, based on the circumstances and dependent on the substantive statutory investigation, who will maintain custody of the scene.

> 2.6.1.1 Any disagreements between SiRT and the RCMP concerning custody of the scene will be referred to the officer who conducted the initial SiRT referral to resolve the disagreement.
>
> 2.6.1.2. Police resources may remain at the scene if requested by SiRT, realizing that the resources stay under the command of the RCMP.
>
> 2.6.2 The primary SiRT and primary RCMP investigators will jointly determine, based on the circumstances and dependent on the substantive statutory investigation, who will take custody and process the exhibits.
>
> 2.6.2.1. Any disagreements between SiRT and the RCMP concerning custody of exhibits will be referred to the officer who conducted the initial SiRT referral to resolve the disagreement.[23]

These sections of the H Division policy, which purport to govern both the SiRT and the RCMP, are not supported by corresponding provisions in the memorandum of understanding between the two agencies. These provisions are inconsistent with the SiRT's exclusive authority to make decisions regarding the conduct of criminal investigations of serious incidents involving police.

LESSON LEARNED

The Serious Incident Response Team should maintain control over crime scenes and evidence that pertains to its investigations. When a police agency requires access to a crime scene or evidence controlled by the SiRT, that access should be managed by the SiRT.

Recommendation P.28

SERIOUS INCIDENT RESPONSE TEAM CONTROL OF CRIME SCENES AND EVIDENCE

The Commission recommends that

(a) The *Police Act* and *Serious Incident Response Team Regulations* be amended to clarify that

  (i) the SiRT has exclusive control over investigations of serious incidents involving police; and

  (ii) when the SiRT assumes responsibility for an investigation, the SiRT will immediately assume command of all activities related to the scene, exhibits, investigation, and direction of resources.

(b) Where a police agency, including the RCMP, requires access to a crime scene or exhibit in order to pursue a parallel criminal investigation, that access should be managed in accordance with protocols set by the SiRT.

(c) RCMP *H Division Operational Manual* Chapter 54.1 should be amended to reflect the *Police Act* and *Serious Incident Response Team Regulations*, including the above principles.

RCMP Referral of the Onslow Fire Hall Shooting to the SiRT and Initial Instructions to Subject Officers

We describe the shooting at the Onslow Belmont Fire Brigade hall and the RCMP's response to that incident in Chapter 5 of Volume 2, What Happened. The Onslow fire hall shooting occurred shortly after 10:17 am on April 19, 2020, when Cst. Terence (Terry) Brown and Cst. David (Dave) Melanson fired their carbines toward

David (Dave) Westlake, a civilian employee of the Colchester Regional Emergency Management Organization, and a parked RCMP cruiser occupied by Cst. Dave Gagnon. Cst. Brown and Cst. Melanson subsequently returned to their vehicle and phoned their superior, S/Sgt. Allan (Al) Carroll to report the incident. However, S/Sgt. Carroll did not understand from that call that the members had fired at a civilian. During his testimony, S/Sgt. Carroll reflected that when he received the call from the constables, "I didn't ask the questions I should have asked. That falls on me." As discussed further below, S/Sgt. Carroll did not learn the details of the incident until later on April 19, when he met with Cst. Brown and Cst. Melanson at the Bible Hill detachment after the conclusion of their shift.

As set out in Chapter 5 of Volume 2, What Happened, Cst. Brown and Cst. Melanson were not directed to stand down from their duties, and nor were they separated from one another after discharging their carbines at the Onslow fire hall. Further, S/Sgt. Carroll explained that he and Acting Insp. Stephen (Steve) Halliday met collectively with Cst. Brown and Cst. Melanson after they returned to the Bible Hill detachment at the conclusion of their shift. They briefly discussed the incident, and it was at this point that S/Sgt. Carroll learned that the shooting happened at a fire hall, and that the officers had shot at a civilian.

The *SiRT Regulations* require the chief officer of the subject police agency to ensure "to the extent that it is practicable, that all the police officers involved in the serious incident are segregated from each other until [the SiRT] or the investigating agency has finished interviewing all of the witness police officers."[24] The *SiRT Regulations* state further that "[u]nless otherwise directed by the person in charge of the investigation, a police officer who is segregated under subsection (1) must not communicate about the details of the serious incident with any other police officer who was involved in the incident until after the [SiRT] or the investigating agency has finished interviewing all of the witness police officers."[25] The memorandum of understanding between the SiRT and H Division states that the "RCMP will take steps to ensure compliance with regulations under the *Police Act* regarding the separation of officers in all matters identified as Serious Incidents." Chapter 54.1 of the *H Division Operational Manual*, which addresses SiRT investigations, contains no direction regarding the requirement to separate subject officers. Cst. Brown testified that he had not received training on what happens after a member discharges a firearm on duty.[26]

Insp. Bell made the referrals to the SiRT regarding the Onslow fire hall shooting and the shooting of the perpetrator at the Enfield Big Stop gas station. As set out

above, Insp. Bell referred the incident involving the shooting of the perpetrator to the SiRT at about 11:50 am on April 19. In his interview with the Commission, Insp. Bell could not recall what time he notified the SiRT of the Onslow fire hall shooting. The SiRT investigative log and Insp. Bell's notes indicate he first notified SiRT investigator Keith Stothart of a possible "blue on blue" shooting at about 1:25 pm on April 19. In Volume 2, What Happened, we explained that "blue-on-blue" refers to a circumstance in which a police officer shoots at a fellow officer. Investigator Stothart's notes indicate that the location of the incident and the identities of the officers involved were not relayed at that point. His notes of the call record uncertainty about whether this blue-on-blue incident was related to Cst. Chad Morrison. (As is evident from the account supplied here and in Chapter 5 of Volume 2, What Happened, the incident involving Cst. Morrison had no connection to the Onslow fire hall shooting.) Mr. Stothart's notes of his conversation with Insp. Bell read:

> 1325 hrs.
>
> Insp. BELL called to advise there may have been an accidentally [*sic*] shooting by a RCMP member at another RCMP member, he will obtain further details and call back.
>
> Cst. Chad MORRISON is injured and drove to Milford EHS for treatment, was he shot by another member?[27]

At around 1:52 pm on April 19, Insp. Bell's notes indicate that he "took on the task of getting details on [the] blue-on-blue situation and making the referral to SiRT."[28] In his interview with the Commission, he could not recall whether someone directed him to make the referral or he offered, stating, "[i]t was just everybody trying to contribute, check off a box … on an extensive task list that needed to be done."[29] At about 3:00 pm on April 19, Insp. Bell discussed the details of the blue-on-blue incident with S/Sgt. Carroll. Insp. Bell's notes of this call record the names of the subject officers and identify Cst. Gagnon as also being involved. However, they do not mention that Cst. Brown and Cst. Melanson fired their carbines at a civilian. Insp. Bell's handwritten notes state:

> The two members believed to have discharged firearms were Cst. Terrence Brown and Cst. Dave Melanson. Believed that both fired C8 Patrol Carbine in incident. 3rd member at scene was Dave Gagne [*sic*] who was wearing camo gear. Report at the time was 5 rounds (approx.) fired, all of which missed intended target and went into fire hall building and fire

> truck at Onslow Fire Hall shortly after 1000 hrs. The Onslow F.H. was being used as a comfort center on Hwy #2 at the time.[30]

At about 3:05 pm on April 19, Insp. Bell phoned Investigator Stothart to provide further details of the possible blue-on-blue shooting he reported earlier. Investigator Stothart's notes record the call as follows:

> 1509 hrs. Insp. BELL called to advise he had further details on the shooting by members earlier in the day
>
> -Subject PO are Dave MELANSON and Terry BROWN
>
> -AP GAGON [*sic*] from Pictou RCMP, he was wearing camo[31]

The SiRT referral intake form completed at that time states:

> Insp. Rob BELL RCMP Halifax District is reporting two RCMP members fired five rounds at another member, who was wearing camo- near the Belmont/Onslow Fire Department. The Fire Hall was used for evacuees from the Portapique area. The two members were searching for a male who was the subject of a massive manhunt for the last several hours and was suspected in killing several individuals, burning several residences, while driving a replica RCMP police vehicle.

As we explained in Chapter 5 of Volume 2, What Happened, Cst. Gagnon was not wearing camouflage at the time of the Onslow fire hall shooting. He was dressed in an RCMP general duty uniform and hard body armour. In fact, Cst. Brown and Cst. Melanson stated they had not seen Cst. Gagnon before opening fire. As noted above, their shots were aimed at Mr. Westlake, a civilian employee of the Colchester Regional Emergency Management Organization, who was wearing an orange reflective vest. However, Insp. Bell's and Investigator Stothart's notes of the call do not state that the subject officers fired at a civilian. The SiRT referral intake form identified the only "affected person" as Cst. Dave Gagnon. Insp. Bell's handwritten notes of the call state that "Stothart advised that it was not a priority to investigate this scene at this point due to # of active scenes, multiple referrals, no reported injuries, etc."[32]

At about 4:08 pm on April 19, SiRT investigator Ron Legere arrived at the Bible Hill detachment. He met with S/Sgt. Carroll, who "provide[d] him the details [he] knew of the incident."[33] As noted above, prior to Investigator Legere arriving,

S/Sgt. Carroll had met with Cst. Brown and Cst. Melanson at the Bible Hill detachment and learned that the officers had shot at a civilian at the fire hall. However, Investigator Legere's notes of his conversation with S/Sgt. Carroll refer only to the officers firing at Cst. Gagnon. They do not mention that the officers fired at a civilian: "At the time of the shooting there was reason to believe that the suspect may be travelling in the direction of the firehall and the officers fired at the A.P. (Cst. GAGNON) believing he was the suspect. Rounds had struck the firehall and also a fire truck. There were no injuries. Nothing had been seized prior to my arrival."[34]

S/Sgt. Carroll's notes state that Cst. Melanson and Cst. Brown then joined S/Sgt. Carroll and Mr. Legere in S/Sgt. Carroll's office, and Mr. Legere "explained the process to them." Investigator Legere's investigative log states in part: "I met with both subject officers in a small room off of the main bull pen area. A union representative had been contacted and they were awaiting his arrival. I had previous[ly] told the officer that I would be seizing both Carbines after confirming all shots were from the carbine and not their service pistol."[35]

At about 4:45 pm, Investigator Legere and S/Sgt. Carroll attended the Onslow Belmont Fire Brigade hall, where Cst. Gagnon had remained on scene. Cst. Gagnon advised the SiRT investigator of the civilians involved in the incident, specifically Dave Westlake, Richard Ellison, Onslow Belmont Fire Brigade chief Greg Muise, and deputy chief Darrell Currie. The impact of the Onslow fire hall shooting on these individuals and the Onslow community is discussed in Chapter 5 of Volume 2, What Happened.

The *Police Act* requires police agencies to refer all serious incidents to the SiRT as soon as practicable. Consistent with the *Police Act*, H Division policy directs that referrals to the SiRT must be made as soon as practicable and must provide a detailed account of the circumstances of the incident. The policy states that commissioned officers (or an officer acting in the role of a commissioned officer), district advisory non-commissioned officers (NCOs), watch commanders, and risk managers can make referrals to the SiRT. The policy also states that "Detachment, District, and Unit Commanders are to contact their District Advisory NCO (Risk Manager if after hours) or Line Officer who will initiate the referral to SiRT."[36]

We make two observations regarding H Division's protocols immediately following a serious incident involving their members. First, it is critical that members in supervisory positions understand what steps they must take when a member discharges a firearm on duty or is otherwise involved in a serious incident. This

includes understanding what information must be obtained about the incident and reported to the SiRT as soon as practicable, and who is responsible for ensuring this is done. Second, H Division must ensure its members and their supervisors know and follow the requirement to separate involved police officers (both witness officers and subject officers) after a serious incident in order to protect the integrity of the SiRT's investigation.

MAIN FINDING

After the Onslow fire hall shooting, the RCMP failed to adhere to its policies and the *Serious Incident Response Team Regulations* with respect to the procedures that must be followed after a serious incident that attracts SiRT jurisdiction.

LESSON LEARNED

It is important for police officers and their supervisors to know what to do when a serious incident that may attract Serious Incident Response Team jurisdiction occurs, and it is important that the *Serious Incident Response Team Regulations* be observed.

Recommendation P.29

KNOWING WHAT TO DO WHEN SERIOUS INCIDENT RESPONSE TEAM JURISDICTION ARISES

The Commission recommends that

(a) RCMP members in supervisory positions should know what steps they must take when a member discharges a firearm or is otherwise involved in a serious incident that attracts Serious Incident Response Team jurisdiction. This includes knowing:

  (i) who is responsible for reporting a serious incident;

(ii) how to make such a report;

(iii) the timeline on which such a report must be made;

(iv) what information the reporting officer must obtain and provide to SiRT about the incident; and

(v) to separate involved members (both witnesses and subject members) immediately after a serious incident occurs.

(b) Any failure to follow these procedures should be documented in writing by the RCMP, and a copy of that document should be provided to the SiRT.

(c) The RCMP should ensure that H Division members receive training in applicable legislation, RCMP policy, and their obligations and rights with regard to SiRT investigations. This instruction should be incorporated into annual use of force / incident response requalification training.

(d) Supervisory training courses and annual use of force / incident response curriculum should include instruction on legislation, RCMP policy, members' obligations and rights, and requirements of supervisors with regard to SiRT investigations.

We acknowledge that the facts upon which these recommendations are based involved unprecedented, chaotic circumstances. This highlights the importance of training to ensure that implementing these policies becomes second nature, particularly in challenging circumstances, when they are most likely to be required.

Supports and Information to Individuals Affected

The memorandum of understanding between the RCMP and the SiRT is silent regarding the allocation of responsibility to provide support to victims of serious incidents involving RCMP members. However, H Division policy states, "[w]hen

carriage of the file belongs to SiRT, they are responsible for ensuring assistance and support is provided to the victim." The policy states further that "SiRT does not maintain a victim services employee" but "[f]or investigations within RCMP jurisdiction, SiRT has been provided a Victim Services contact list in order to fulfill their assistance and support role."[37] The SiRT does not necessarily have access to RCMP policies, nor is the SiRT governed by RCMP policies. The Commission is not aware of any corresponding SiRT policy regarding its responsibilities or protocols with respect to supports for individuals affected by serious incidents involving police officers. The matter is not addressed in the *SiRT Regulations*. The SiRT's 2020–2021 annual report states that SiRT investigations generally include "notifying next of kin and liaising with the family of the deceased or injured parties to keep them informed" and "appointing a community liaison to work with the affected party and the [SiRT], where appropriate."[38] However, during the roundtable on police oversight, supervision, and accountability, SiRT investigator Luc Côté indicated that victim services are not necessarily available to individuals affected by serious incidents involving police: "I think it's critically important as well that victims services are provided to those affected by the actions of police which we're investigating. For us, obviously we're a very small office, and it is an important part that we don't have available for our service, which is access to service for the victims, those affected by police action."[39]

The information we received suggests a gap with respect to the provision of supports and information to individuals affected by serious incidents involving police officers. Chief Muise stated that after he was interviewed, the SiRT did not reach out to him to update him on the investigation. The SiRT did not notify him when they finalized their report, nor did they offer Chief Muise or Deputy Chief Currie any supports. Nearly a year after the Onslow fire hall shooting they were offered supports through RCMP Victim Services after meeting with the RCMP's Hazardous Occurrence Investigation Team (HOIT). Sharon McLellan, witness to the Onslow fire hall shooting and member of the Onslow community, also told the Commission that after the SiRT investigator interviewed her, she did not receive follow-up regarding how she was doing or what supports she might need. The SiRT did not contact her prior to the release of their report. The SiRT also did not offer Mr. Westlake mental health support during the investigation.

LESSON LEARNED

Individuals who are affected by serious incidents involving the police are entitled to receive updates about a SiRT investigation and may require victim support services.

Recommendation P.30

PROVIDING SUPPORT TO SERIOUS INCIDENT RESPONSE TEAM WITNESSES

The Commission recommends that

The Serious Incident Response Team establish or revise its procedures to ensure that witnesses and other individuals affected by serious incidents involving the police are provided with updates about the progress of the SiRT investigation and are referred to available support services.

The SiRT's Public Accountability Function

The SiRT has a law enforcement mandate (that is, conducting criminal investigations and deciding whether to lay charges) and also provides a critical public accountability function. The 2017 Tulloch Report addresses this function in relation to the Special Investigations Unit (SIU), which is Ontario's equivalent body to the SiRT:

> 4.620 – Public accountability
>
> 82. The SIU is different from other law enforcement agencies in Ontario. Like other law enforcement agencies, one of its core functions is to

> effectively investigate possible crimes. But unlike other law enforcement agencies, it has an equally important public accountability function.
>
> 83. That function ultimately aims to promote public confidence in law enforcement. This is done by holding police accountable for any potential criminality, and by showing the public that this has been done.[40]

Public reporting of the SiRT's decisions is the key mechanism by which the SiRT maintains public accountability. The SiRT's decisions are final. They are not subject to any appeal or review process.[41] When the SiRT decides not to lay charges against a police officer involved in a serious incident, it is critical that the decision is explained to the public with enough information to allow the public to meaningfully understand and evaluate the SiRT's reasoning.

The Tulloch Report explains the necessity of transparent public reporting as follows:

> 100. To fulfill its purpose, the SIU must provide the public with enough information so that members of the public can know the relevant evidence, assess whether it was properly analyzed, and closely examine whether the director's conclusions are sound.
>
> 101. Otherwise, the public will remain suspicious of both the SIU and the police, whether investigations are effective or not.[42]

If, for instance, the SiRT prefers the evidence of a subject police officer over conflicting evidence from a civilian witness on a material fact, the SiRT should state this, and explain why.

Section 9(2) of the *SiRT Regulations* prescribes what information the SiRT must include in its public reports as follows:

> Summary of investigation
>
> 9 (2) A summary must include all of the following:
>
> (a) a summary of facts;
>
> (b) the time frame of the investigation;
>
> (c) a statement of the number of civilian witnesses and witness police officers interviewed;
>
> (d) a statement of the relevant legal issues;

> (e) the decision whether a charge will be laid.
>
> (3) A summary may include the names of the subject police officers and witness police officers involved in the investigation.
>
> (4) If it is decided that no charge will be laid, a summary may include reasons for that decision.

The SiRT report on the Onslow fire hall shooting (referred to as the "Onslow SiRT Report") includes the elements set out in section 9 of the *SiRT Regulations*. However, it does not provide enough information to allow the public to understand and evaluate the SiRT's conclusions.

The Onslow SiRT Report lists the types of evidence the SiRT reviewed, but does not identify what evidence the SiRT relied upon in making particular findings. For instance, a member of the public cannot know from reading the report what evidence underlies the SiRT's finding that prior to firing their carbines, the constables yelled "police" and "show your hands," and nor is it apparent that the SiRT received contradictory evidence on this point. There are no photographs, radio transcript excerpts, or witness statement excerpts included in the report, and it does not refer to any police training or policy.

The Onslow SiRT Report states that the SiRT reviewed an expert report on the use of force. However, it does not set out the expert's opinion, or state whether the SiRT relied on that opinion in reaching its conclusion that the constables' use of force was authorized under section 25 of the *Criminal Code*. Through the Commission's process, we learned that then SiRT director Felix Cacchione did not rely on the expert opinion the SiRT obtained in the Onslow fire hall shooting investigation because he was concerned that it was "kind of one sided." This issue is discussed further in the next section of this chapter.

The Onslow SiRT Report identifies factors that support its conclusion that the constables had reasonable grounds to fire their carbines at Mr. Westlake. However, the report does not indicate whether the SiRT considered, accepted, or rejected any evidence that did *not* support the reasonableness of the constables' use of force. Where the SiRT finds that the subject officers had reasonable grounds to believe their use of force was necessary under section 25 of the *Criminal Code*, a report that provided a basis for public understanding would identify evidence that weighs *against* that conclusion and explain why the force was authorized in spite of that evidence. When a report does not do so, the public may be left with the impression that evidence adverse to the director's findings was not considered.

Although the SiRT director is required to publicly release a report within three months of the conclusion of an investigation, these reports are only a summary of the actual investigative file. In the cases of the Onslow fire hall shooting and the shooting of the perpetrator in Enfield, the SiRT investigative files subpoenaed by the Commission were each more than 1,000 pages long and contained photographs, evidence, and witness statements. The reports issued *publicly* in those cases were respectively six and four pages long.

The SiRT report on the shooting of the perpetrator (referred to as the "Enfield SiRT Report") states that "[t]he facts as found in this report are based on a review and consideration of all the evidence obtained during the investigation"[43] and lists the categories of evidence the SiRT reviewed. However, as with the Onslow SiRT Report, members of the public who read the Enfield SiRT Report cannot know what the material evidence was. Photographs and videos are not reproduced in any format, nor are they described, and key evidence from witness statements, including those of the subject officers, is not summarized or excerpted. The SiRT sets out its findings of fact without telling the reader what evidence they are based on, and does not state whether there were any contradictions in the evidence that were resolved by the SiRT in order to reach its conclusions. The report also refers to an expert use of force report but does not set out the expert's opinion or indicate whether the SiRT relied on that opinion. Like the Onslow SiRT Report, the Enfield SiRT Report does not identify any circumstances that were adverse to the director's ultimate conclusions. In both reports, the application of the relevant legal tests to the facts is not explained with sufficient detail to allow the public to meaningfully evaluate the reasoning.

The Commission heard from several witnesses and Participants who were directly affected by the Onslow fire hall shooting that the SiRT report did not instill confidence in the investigation of that incident. Counsel for a group of Participants, including some who were present during the shooting, submitted that the SiRT investigation "selectively included and excluded evidence to produce an account of events (and thus an investigative result) supportive of the RCMP."[44] Chief David MacNeil of Truro Police Service testified that while he had confidence in the SiRT as an institution, he thought "there should have been a little bit more to the [SiRT's] findings" in that case:

> I just thought there should have been a little bit more of a – I don't know how to explain it. I – nothing to do with the confidence I have in SiRT, just in that case it just seemed to be a little bit of a – I don't know how to put it

> without being – I don't know. To me, … I thought there should have been a little bit more to the findings.[45]

The Tulloch Report explains the connection between transparent public reporting and public trust as follows:

> 11. The problem, however, is that the public is unable to closely examine whether the SIU is doing its job properly. To many of them, it feels like the SIU is telling them to "just trust us."
>
> 12. Without the SIU sharing more information, the public is left to wonder whether each investigation was effective and unbiased or not.
>
> 13. As the Ombudsman put it in 2008, such "secrecy only breeds suspicion."
>
> 14. This is no small problem. It goes to one of the main purposes for which the SIU was created: to promote public trust in policing.
>
> 15. If the public is suspicious of the police, whether rightly or wrongly, the relationship between the police and the public will be damaged.
>
> 16. Thus, the SIU must not only be effective at holding police accountable, but it also must be seen to be effective at doing so.
>
> 17. And if it is not effective, the public must be able to hold the SIU accountable. The public needs to know whether the SIU is doing the job it is supposed to be doing.
>
> 18. For the SIU to fulfill its purposes then, it is crucial that it shares what it has done and how it has made decisions. Transparency and accountability are not just good goals for the SIU, but features essential to its success.[46]

Transparent reporting to the public is essential for the SiRT to fulfill its mandate of "ensur[ing] Nova Scotians have the utmost trust and confidence in the investigation of serious incidents involving police."

The requirements for the minimum content of SiRT reports prescribed in section 9 of the *SiRT Regulations* do not adequately uphold the SiRT's public accountability function. They may be contrasted with the requirements for the SIU's reports set out in section 34 of Ontario's *Special Investigations Unit Act*. Those requirements

are significantly responsive but not identical to recommendations in the Tulloch Report. The relevant provisions of Nova Scotia's *SiRT Regulations* and Ontario's *Special Investigations Unit Act* are set out side by side for ease of comparison on the next page.

Director Cacchione suggested that including more information (specifically, photographs) in the SiRT's reports could have implications for the SiRT's limited resources:

> COMMISSION INVESTIGATOR: And would there be anything that would preclude the inclusion of appropriate photographs to help the public understand the flow of the investigation and the decision that came out of it, to assist them in their understanding?
>
> FELIX CACCHIONE: I don't, I don't see there's anything that would preclude the inclusion of photographs in our report, but I think if you start doing that, you're going to start having requests for the entirety of your file. And, you know, if there's one person in the SiRT office who does everything – fields the phone calls with public referrals, deals with Freedom of Information requests and deleting information that can't be disclosed and redacting those documents, managing the office, you know, the budget, all of that stuff – you start saying, "well, yeah, we're going to include photographs" then the public will want to see all of the photographs. And sometimes you're talking hundreds of photographs. We don't have the resources to do that. There'd be ... the policing agency involved and the Minister get everything; they know what's in the file ... Yes, it may be useful, but I think it would present more problems, certainly logistically and resource wise for us. I keep saying "us," I'm not there anymore.[47]

Like Director Cacchione, former SiRT Interim Director Curran also emphasized that the SiRT has only one administrative staff person, and that person is responsible for myriad functions including communicating with media, responding to *Freedom of Information and Protection of Privacy Act* applications, and typing documents. He stated, "[t]here is only one support person in a job that undoubtedly requires several, and it's able to function only because of the extraordinary ability and effort of the person that happens to be there."[48] Interim Director Curran opined that "when [the current office staff person] retires, they'll need several persons ... to replace her."[49] In addition to this discussion regarding the SiRT's limited

Nova Scotia SiRT Regulations	Ontario Special Investigations Unit Act
Summary of investigation 9 (2) A summary must include all of the following: (a) a summary of facts; (b) the time frame of the investigation; (c) a statement of the number of civilian witnesses and witness police officers interviewed; (d) a statement of the relevant legal issues; (e) the decision whether a charge will be laid. (3) A summary may include the names of the subject police officers and witness police officers involved in the investigation. (4) If it is decided that no charge will be laid, a summary may include reasons for that decision.	*Public notice if no charges laid against official re incident* 34 (1) If an investigation under section 15 does not result in charges being laid against an official, the SIU Director shall publish a report on the website of the Special Investigations Unit containing the following information: 1. The reasons why the investigation was thought to be authorized under section 15. 2. A detailed narrative of the events leading to the investigation. 3. A summary of the investigative process, including a timeline noting any delays. 4. A summary of the relevant evidence considered, subject to subsection (2). 5. Any relevant video, audio or photographic evidence, de-identified to the extent possible, subject to subsection (2). 6. The reasons for not laying a charge against the official. 7. Any other information that may be prescribed. *Omission and reasons* (2) The SIU Director may omit from the report any information required to be provided under paragraph 4 or 5 of subsection (1), if the SIU Director is of the opinion that a person's privacy interest in not having the information published clearly outweighs the public interest in having the information published, and includes in the report the reasons for the omission. *Excluded information* (3) The SIU Director shall ensure that the following information is not included in the report: 1. The name of, and any information identifying, a subject official, witness official, civilian witness or affected person. 2. Information that may result in the identity of a person who reported that he or she was sexually assaulted being revealed in connection with the sexual assault. 3. Information that, in the opinion of the SIU Director, could lead to a risk of serious harm to a person. 4. Information that discloses investigative techniques or procedures. 5. Information, the release of which is prohibited or restricted by law. 6. Any other information that may be prescribed.

administrative resources, we also heard evidence about limitations with respect to the SiRT's investigative capacity. That evidence arises in relation to the July 2020 referral addressed in the final section of this chapter.

MAIN FINDING

The minimum content provided in section 9 of the *Serious Incident Response Team Regulations* for public reports issued by the SiRT is inadequate to discharge the public accountability function performed by the SiRT. Staffing and budget constrain the SiRT's capacity to provide more detailed public reports than it presently supplies.

Communications Between the SiRT and the RCMP

Appointment of an RCMP Liaison for Communications with the SiRT

The memorandum of understanding between the SiRT and RCMP H Division states that, for SiRT investigations of RCMP members, the RCMP will "when possible" appoint a liason to act as a conduit between the RCMP and the SiRT with respect to the investigation: "When an RCMP officer is the subject of a SIRT investigation, RCMP will appoint a senior NCO when possible to act as a Liaison Officer. The Liaison Officer will act as a conduit between the RCMP and SIRT for all matters related to the investigation."[50] According to the memorandum of understanding, the SiRT is expected to provide updates on the progress of an investigation to the RCMP "upon a receipt of a request from the Liaison Officer or OiC Criminal Operations or delegate."[51]

Evidence given by C/Supt. Leather and C/Supt. Gray suggested that, in practice, the question of who within H Division may communicate with the SiRT during

ongoing investigations is not subject to strict protocols and instead depends on the circumstances and the purpose of the communication. It is unclear from the information before the Commission whether there was an RCMP liaison for the SiRT investigations related to the mass casualty. Communications between the RCMP and the SiRT about these investigations did not flow through a single RCMP member.

Among the communications recorded in the SiRT investigative logs were calls from Cst. Brown (one of the subject officers in the SiRT's investigation of the Onslow fire hall shooting) to SiRT investigator Ron Legere and to SiRT investigator Kevin Hovey (who took over the SiRT file after Investigator Legere concluded his SiRT secondment). Cst. Brown contacted the SiRT investigators to ask for updates on the status of the investigation and in one instance, inquired as to whether the SiRT was responsible for Cst. Brown being placed on administrative duties. On November 19, 2020, Investigator Hovey recorded the following phone call from Cst. Brown:

> Received a call from Subject Officer Terry Brown looking for an update. I explained to him that I am waiting [for] a Report from the Use of Force expert and the transcripts for the radio Broadcasts. He wanted to know if the investigation would be done by the end of the year. I explained that I could not promise that as I would have to review the file when these reports were completed and determine if there are further investigative avenues, the[n] a report goes to the Director to make the final decision.[52]

Interim Director Curran acknowledged based on these notes that this was "a pretty sizable communication," although it "doesn't give away any details."[53] He stated, "I might be uncomfortable dealing with a call like that myself," but "I don't know there's harm in [it]"[54] and "I don't see any problem with it from SiRT's standpoint."[55] C/Supt. Leather stated that a communication from a subject officer to the SiRT investigator during an ongoing investigation is inappropriate if it pertains to the investigation. However, "[i]f it was an innocuous request about something not related to the investigation, then perhaps there could be an explanation."[56]

The evidence we received suggests that H Division and the SiRT lack clear protocols regarding their communications during ongoing investigations of H Division members. In our view, communications between the SiRT and H Division about ongoing investigations of RCMP members should be kept to a minimum, and

should be carried out only by a designated RCMP liaison. An officer who is the subject of a SiRT investigation should not communicate directly with the SiRT investigator (outside of providing evidence or information to the SiRT) during ongoing investigations.

LESSON LEARNED

Communications between the Serious Incident Response Team and the police agency that employs an officer who is subject to a SiRT investigation should be kept to a minimum, and should only be carried out by a designated liaison within the subject police agency. An officer who is the subject of a SiRT investigation should not communicate directly with the SiRT investigator (outside of providing evidence or information to the SiRT) during ongoing investigations.

Recommendation P.31

RCMP LIAISON WITH THE SERIOUS INCIDENT RESPONSE TEAM

The Commission recommends that

(a) RCMP H Division policy should be amended to provide that all RCMP communications and coordination with the Serious Incident Response Team regarding an ongoing investigation must occur through a designated RCMP liaison, who must be a commissioned officer and trained in the responsibilities and expectations of this role. The SiRT should also implement a corresponding policy requiring its investigators not to communicate about ongoing SiRT investigations with members of the subject police agency besides that agency's designated liaison person.

(b) The only purpose for which any other RCMP member may communicate directly with SiRT about an ongoing investigation is when giving a statement or witness interview, which must be coordinated through the RCMP Liaison Officer.

Information Sharing Between Concurrent Investigations

Following the mass casualty, the SiRT conducted its investigations of the Onslow fire hall shooting and the shooting of the perpetrator concurrently with the RCMP's H-Strong investigation. Various communications between the SiRT investigators and the RCMP H-Strong investigators are recorded in the SiRT's investigative files. C/Supt. Leather explained that he would expect that there would be "fairly extensive" communication between the SiRT and H-Strong investigators, stating that "the amount of H Strong investigative requirements of both [SiRT] scenes would require the sharing of information."[57] H-Strong team commander Acting Sgt. Angela McKay told the Commission there were "numerous conversations" and "open communication" between the H-Strong investigators and SiRT investigators. She said there were phone calls back and forth as well as in-person communications, and that these were not "formal sit down meetings." In addition to information sharing between the concurrent criminal investigations, the RCMP also asked the SiRT to share material from its ongoing investigation for the purposes of RCMP conduct files and a civil claim for damages pertaining to the Onslow fire hall shooting. As discussed in more detail below, the SiRT also shared and discussed investigative material during its investigation of the Onslow fire hall shooting with the RCMP Hazardous Occurrence Investigation Team.

Interim Director Curran suggested that the SiRT may properly share information about an ongoing investigation of RCMP members with other RCMP members who are responsible for conducting internal investigations related to the incident. Specifically, Interim Director Curran was asked to comment on two April 23, 2020, phone calls from Acting Insp. Halliday to SiRT investigator Legere regarding the Onslow fire hall shooting. According to Investigator Legere's notes, he "spoke with Halliday and at his request provided him a brief overview of the Onslow Fire Station, Discharge of firearms investigation."[58] Later the same day, Investigator Legere received a second call from Acting Insp. Halliday "who requested further confirmation on the position of WESTLAKE and G[A]GNON at the time of the shooting."[59] Interim Director Curran stated that this communication "wouldn't be something that would come up in ordinary circumstances, because well, we're generally not dealing with the RCMP in that way at all."[60] However, he stated that if Acting Insp. Halliday had been involved in "an internal RCMP investigation of the propriety of what happened," then he "would not see any real problem with it, if that's what it were."[61]

Section 26L of the *Police Act* states that the SiRT director will make the SiRT investigative file available to the disciplinary authority for the police agency that employs the subject police officer(s) *at the conclusion of* the SiRT's investigation. The Act does not contemplate that the SiRT will share investigative information with the agency that employs the subject police officer(s) while the SiRT's investigation is still ongoing. However, information sharing during concurrent investigations by the SiRT and the RCMP is addressed in their memorandum of understanding, which states that during concurrent investigations, "[the] SiRT and [the] RCMP will make available all relevant investigative material to the other agency" and "[t]his shall be subject to relevant legal considerations." H Division policy provides little guidance for how this works in practice. It states only that "[a]ll contact with and direction provided by SiRT must be recorded on the substantive statutory investigation."[62] When asked whether there was any expectation that evidence shared between concurrent criminal investigations would be approved by the director, Interim Director Curran stated, "I don't think it's possible to generalize because at least in my time and really to my knowledge, this is a one off anyway, that there was no other parallel investigation of the same matter where SiRT was one of the … investigating parties … not that I can recall even hearing about, let alone experiencing."[63]

Director Cacchione also told the Commission that he was not aware of instances of information sharing between the SiRT and the RCMP during concurrent investigations.

We make the following observations regarding the sharing of investigative information by the SiRT in circumstances where the subject police agency conducts a concurrent investigation of the same incident. First, the SiRT should not share its investigative material with the police agency that employs the subject officer(s) for the purposes of any internal investigation by that organization (including, for example, disciplinary investigations or internal workplace investigations) until after the SiRT's criminal investigation is concluded. The same principle applies to disclosure of the SiRT's investigative materials to the subject police agency for the purposes of civil claims related to the serious incident.

However, these principles do not apply to the SiRT's decision-making regarding its co-operation with related investigations by other *external* bodies (for example, an investigation by Employment and Social Development Canada), to whom the SiRT may provide information directly.

In circumstances where coordination is necessary for concurrent *criminal* investigations by the SiRT and the subject police agency, the sharing of evidence from the SiRT to the police agency must be approved in writing by the SiRT director and fully documented.

The need for clear protocols and limits on information sharing between the SiRT and the RCMP is discussed further in the following section, where we address the SiRT's decision to share and discuss with the RCMP an expert report commissioned by the SiRT for its investigation of the Onslow fire hall shooting.

January 2021 Meeting and Memorandum Regarding the SiRT Use of Force Report

During its investigation of the Onslow fire hall shooting, the SiRT retained a retired municipal police officer from another Canadian province to prepare an expert report on the use of force (the "use of force report"). In January 2021, while the SiRT investigation was ongoing, the SiRT shared the use of force report with the RCMP Hazardous Occurrence Investigation Team. The HOIT was investigating the Onslow Fire Hall shooting in accordance with the RCMP's requirements as an employer under the *Canada Labour Code.* We understand that this investigation is ongoing. According to RCMP documents, the HOIT was composed of RCMP members external to H Division. C/Supt. Leather explained that the HOIT reported to C/Supt. John Robin during his tenure as the lead of the Issues Management Team. Prior to C/Supt. Robin's arrival in the division, the HOIT reported to C/Supt. Gray. C/Supt. Robin, who is C/Supt. Gray's spouse, was subsequently removed from his role on the Issues Management Team because of concerns about a perceived conflict of interest. This course of events is discussed further in Chapter 10 of this volume. The SiRT investigative file indicates that Director Cacchione approved the disclosure of the use of force report to the RCMP on January 11, 2021. However, Director Cacchione told the Commission that he did not know why the SiRT disclosed the use of force report to the HOIT. On January 21, 2021, C/Supt. Robin and members of the HOIT met with the SiRT to discuss the use of force report. C/Supt. Robin's handwritten notes of this meeting state:

> 1300 – meeting SIRT
>
> SIRT Bobbie Haynes points out inconsistencies/omissions (apparent) – with [the use of force expert's] report – referencing their review of written report = of [use of force expert]
>
> -I clarify that as we had copy of use of force, we wanted to ensure SIRT aware of apparent conflict in report with available evidence.
>
> -criminal offence committed?
>
> -scope magnification?
>
> -Felix says 'Cst Gagnon' will in no way be blamed for anything'. (although he hasn't completed report). – recognizes[64]

Director Cacchione had no recollection of what was discussed at the meeting and could not remember why it was called. He did not recall saying that "Cst. Gagnon will in no way be blamed for anything" but stated, "If it's in the notes, I probably said that, but I don't have a recollection."[65] Based on the notes of the meeting, he agreed it did not appear to be a typical meeting.

The HOIT also provided a related memorandum, dated January 18, 2021, to the SiRT containing an analysis of the use of force report (the "HOIT Memorandum"). The HOIT Memorandum "identified inaccuracies and omissions within the [use of force report] which the HOIT believe[d] bear relevance on the investigation of this incident." For example, the HOIT Memorandum notes that the use of force report did not reference the Forensic Identification Services findings, sketches, or photographs, or consider the shooting accuracy of the carbine from a distance:

> Although [the use of force expert] referenced having reviewed the FIS report and photographs (p. 3), the FIS examination findings, sketches or photographs are not referenced within the report. A CAD sketch prepared by Sgt. Habib reported the distance from the shell casings to the monument located at the entry way to the Firehall to be 88.34 meters or 289 feet. (See attachment #1) The EMO official was known to be standing behind the marked police vehicle beyond this monument. The distance from which Cst. Melanson and Cst. Brown initially observed the marked police vehicle and EMO official and the distance from which the members discharged their carbines are significant factors. The accuracy of the carbine at distance is also not referred to within the report.[66]

The HOIT Memorandum concludes by stating, "HOIT believe the information as referred to above is critical to understanding the events that transpired at the Onslow Firehall" and that "[t]he HOIT wish to draw this information to the attention of SiRT to ensure the Use of Force expert has taken these factors into account during the drafting of his report."[67]

Director Cacchione noted that it was not normal practice to receive memorandums of this kind from HOIT or any other RCMP unit. He stated, "I never received something like that before or after."[68] Director Cacchione assured the Commission that the meeting and memorandum from HOIT did not impact his decision-making. He perceived no attempt by the RCMP to influence his decision. He stated that in any case, he did not base his decision on the use of force report:

> FELIX CACCHIONE: … I can tell you that [the use of force expert] prepared that report. I can also tell you that I had real concerns with [the use of force expert] and that we never retained him after that, because the report, his report I found to be kind of one sided. But I did not base my report on what [the use of force expert] had to say; I based it on the totality of everything that I reviewed.[69]

MAIN FINDING

Representatives of the Serious Incident Response Team and the RCMP met with one another to exchange information before the SiRT had issued its decision in the Onslow fire hall shooting referral. Their decision to meet reflects a misunderstanding on the part of both the SiRT and the RCMP about their respective obligations to protect the SiRT's independence as a law enforcement and public accountability body.

MAIN FINDING

Evidence raising concerns about the reliability of the expert use of force report commissioned by the SiRT in this instance raises questions about the effectiveness of the SiRT's approach to identifying, retaining, and instructing experts and the role of such experts in its decision-making process.

Recommendation P.32

SERIOUS INCIDENT RESPONSE TEAM PROTOCOL FOR INFORMATION EXCHANGE WITH POLICE AGENCIES

The Commission recommends that

(a) The Serious Incident Response Team should adopt a protocol that it will not meet with members of the police agency that employs a subject officer to exchange information about an ongoing investigation.

(b) The SiRT should also adopt a protocol that sets out how information will be exchanged when two agencies are engaged in parallel criminal investigations. Any such exchange of information must occur in writing.

(c) While a SiRT investigation is ongoing, the SiRT should not share information with the agency that employs the subject police officer(s) for the purposes of an internal investigation conducted by that agency, including internal conduct or workplace investigations.

LESSON LEARNED

It is important that the Serious Incident Response Team retain experts who are independent and able to provide an expert opinion that will meet Canadian legal standards for expert witnesses.

Recommendation P.33

EXPERT WITNESS RETAINED BY THE SERIOUS INCIDENT RESPONSE TEAM

The Commission recommends that

The Serious Incident Response Team should adopt written protocols for the identification and retention of experts in its investigations. These protocols should reflect Canadian legal principles with respect to the reliability and independence of expert witnesses.

In making this recommendation, we make no comment on the quality of the use of force report commissioned in this instance, or its author.

March 2021 Meeting About the TMR2 System

The Onslow SiRT Report contained analysis of the RCMP's Trunked Mobile Radio 2 (TMR2) radio records and concluded that attempts by the subject officers to notify other officers of what they were seeing at the fire hall "were unsuccessful due to the heavy volume of radio traffic."[70] On March 5, 2021, after the SiRT published its report finding that no criminal charges were warranted in the Onslow fire hall shooting, it received an email from Todd Brown, a provincial government employee at the Public Safety and Field Communications Division of the Department of Service Nova Scotia and Internal Services.

In this email, Mr. Brown explained that his office "manages the TMR2 system with its service provider (Bell Mobility)" and "[t]he RCMP is a user of the system."[71] Mr. Brown expressed surprise that the SiRT had not contacted his office for information related to the investigation of the Onslow fire hall shooting, noting that the province has "multiple IT tools that allows us to do our own forensic analysis of network performance," which the RCMP does not have access to. The email also raised questions regarding the accuracy of a particular statement in the SiRT's report. It states in part:

> Additionally, with respect to one part of analysis, the report states:

> "The sole reason why SO2 [subject officer 2] was unable to transmit what they were seeing was because there was no available talk path due to the heavy volume of radio traffic"
>
> This may or may not be accurate, we don't know. There are multiple things that could have affected whether or not the officers got access to a channel. Just a couple of examples to illustrate.
>
> Whether other mostly RCMP users of the tower site servicing Onslow were properly trained. Improperly trained users can consume limited network capacity (network capacity for a radio frequency based network is limited and federally regulated).
>
> What kind of vests the officers were wearing … depending upon the material, this can affect whether users get a channel …[72]

The email concludes with an offer to provide additional information about the TMR2 system if the SiRT had questions about it. After receiving the email, the SiRT contacted the RCMP for assistance in responding to Mr. Brown's questions. On March 9, 2021, C/Supt. Leather wrote to Director Cacchione and offered to arrange a meeting to discuss the matter further. Director Cacchione replied, stating, "I would like as much information as possible before I respond to Mr. Brown and a meeting with yourself and C/Supt. Robin would be of assistance."[73] The meeting occurred between March 12 and 14, 2021.[74] Director Cacchione described the purpose of this meeting between the RCMP and the SiRT as follows:

> FELIX CACCHIONE: [The] meeting was about the comment that is captured in that email. The sole reason why SO2 was unable to transmit what they were seeing, was because there was no available talk path due to the havy volume of traffic.
>
> …
>
> FELIX CACCHIONE: The meeting was initiated because of that comment and the purpose of the meeting was to educate me about the radio communications that took place … from the time the [subject officers], this is Onslow, were called to duty until they fired …[75]

Director Cacchione recalled RCMP Operational Communications Centre commander Mr. Glen Byrne providing information during the meeting, but he did not know why other RCMP officers, specifically, C/Supt. Leather, Supt. Darren

Campbell, and Insp. Sean Auld, attended the meeting. C/Supt. Leather described the meeting as being "about volumes of transmissions and it's a technical conversation."[76] He acknowledged it was a "[b]it of an unusual meeting," however:

> We're of course, interested in knowing … if there is a system issue that technically or mechanically, we need to be aware of so it can be addressed [for] will inevitably be other volume transmission events, it only makes sense that we would become aware of that as soon as possible to discuss it. It seemed to come out during the course of this Onslow Fire Hall investigation, and this was something that Felix thought he should bring to our attention.[77]

C/Supt. Leather described the reason why the various RCMP officers attended this meeting as follows:

> Darren Campbell was there because Support Services, which includes OCC (Operational Communications Centre) roll up under him… The OCC, of course, is where calls are dispatched from and is where the transmissions are being received by, so OCC is the natural touchpoint for the Division and for the RCMP for that. John Robin because he was overseeing the HOIT investigation … Glen Byrne because he is and was the manager of OCC, and I guess myself because of my oversight of the Support Services program. So in terms of why we were there, it does make sense.

There was some uncertainty as to whether or not Mr. Brown himself attended the meeting along with the members of the SiRT and the RCMP. Director Cacchione recalled Mr. Brown being present. However, C/Supt. Leather stated, "I don't believe Mr. Brown was present, but his email, as I recall, was certainly front and center."[78] We conclude from subsequent email correspondence between Mr. Brown and C/Supt. Robin that Mr. Brown was not notified of, and did not attend, the meeting. Specifically, on March 30, 2021, Mr. Brown wrote to C/Supt. Robin stating that the SiRT had yet to acknowledge or respond to Mr. Brown's email about the SiRT's report.

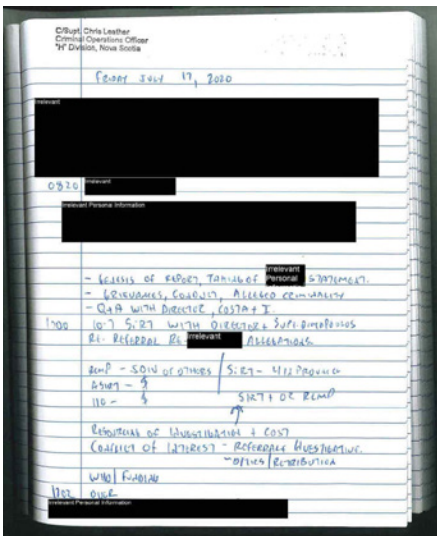
This incident is connected to the SiRT's reliance on the RCMP for specialized services and technical assistance in its investigations of RCMP members and the corresponding recommendations we have made above.

July 2020 Referral to the SiRT

In Chapter 5 of this volume, we explained that Issues Management Team member Supt. Constantine (Costa) Dimopoulos took some steps toward conducting operational debriefing with general duty RCMP members who responded to the mass casualty in June 2020. However, these efforts were abandoned when Supt. Dimopoulos received information from an RCMP member alleging prior misconduct by members of a municipal police agency. The allegations included potentially criminal conduct and misconduct under the *Police Act* and were referred to the SiRT.

The Commission first learned of the July 2020 referral in August 2022. The substance of the allegations do not relate to the mass casualty or the perpetrator; therefore, the identities of the witnesses, individuals, and police agency that are the subject of the allegations are not requisite to the Commission's work. However, as addressed below, the allegations are serious and the information we received indicates they have not been investigated. Commission counsel brought these allegations to the attention of the Nova Scotia minister of justice to consider whether further steps are required. In order to protect the integrity of any consequent investigation, we have provided only general information about the nature of the allegations made.

On July 7, 2020, C/Supt. Leather, C/Supt. Gray, and Supt. Dimopoulos met with A/Commr. Bergerman, the commanding officer of H Division, to brief her on the allegations. On July 10, 2020, H Division sent a situation report to RCMP national headquarters advising that H Division had received information about members of a municipal police service that included potential *Police Act* violations as well as allegations of "a serious criminal nature," and that H Division would be referring these allegations to the SiRT.


C/Supt. Leather's notes of the meeting held July 17, 2020, COMM0065182, p. 4. (Redactions placed by Attorney General of Canada)

On July 13, 2020, H Division referred the allegations to the SiRT by email, enclosing several documents including a letter of referral, a memorandum from Supt. Dimopoulos, notes, and a transcription of a witness interview (the "July 2020 Referral"). On July 17, 2020, C/Supt. Leather and Supt. Dimopoulos met by phone with

SiRT director Felix Cacchione to discuss the referral. C/Supt. Leather's handwritten notes of the call are set out here. In these notes, the abbreviations "ASIRT" and "IIO" refer to the Alberta SiRT and the Independent Investigations Office of British Columbia, respectively.

C/Supt. Leather recalled that during this meeting, Director Cacchione indicated the SiRT would be accepting the referral but was concerned about the cost and human resource requirements of the investigation:

> C/Supt. LEATHER: … We move from a discussion about [the SiRT] accepting the referral to resourcing the investigation and discussions about what role, if any, the RCMP could play, and some of the concerns and issues he raised about capacity to undertake such an investigation.
>
> [COMMISSION COUNSEL]: Sorry. So your understanding was the Director was telling you SiRT would be willing to investigate, but had some concerns about its capacity or resources to do so?
>
> C/Supt. LEATHER: Yes, the cost, overall, of such an investigation and then the human resource requirements in terms of their footprint being four investigators for all matters of SiRT, and that that would have to be either bolstered or some sort of referral made to another agency to undertake the investigation and even a discussion as to whether or not the RCMP, you know, from another division, for instance, might be positioned to undertake the investigation.[79]

C/Supt. Leather explained that units such as the Alberta SiRT or the Independent Investigations Office of British Columbia "were discussed but would be costly to be brought in to undertake the investigation."[80] C/Supt. Leather told the Commission that his impression was that "the cost of the investigation was front and center in the [SiRT] Director's mind and their ability to undertake the investigation."[81] According to C/Supt. Leather, Director Cacchione was looking to the RCMP to assist with funding or human resources for the investigation. C/Supt. Leather stated that, for him, the possibility of RCMP funding the investigation was a "non-starter."[82] He was also concerned with "the optics of the RCMP in any capacity being involved in the investigation,"[83] including by providing specialized support services.[84] C/Supt. Leather was worried that any RCMP involvement could give rise to a perceived conflict of interest and that the investigation could be "viewed as retributive … given the timing and who the complaints were against, etc."[85] He

recalled "a collective sense at the table around the optics of the timing of this investigation, the nature of the investigation, how would [it] be perceived by the public and also by members of all police services in the province and perhaps even by Government" and "that wasn't lost on any of us during the course of the discussion."[86]

C/Supt. Leather stated further:

> But I have to say, it is what it is. It's unfortunate that the information came to us at that particular time, but this was not something that we sought; it came to us through the normal course of our reviews, and we were seized with the information and the referral needed to be made. And yes, the timing – most unfortunate, but we had to make the referral, we did so. And these were, this was the nature, as I say, of the discussion with Mr. Cacchione.[87]

Supt. Dimopoulos recalled that Director Cacchione asked H Division "to provide some recommendations with regard to possible ways forward for SiRT" to investigate the allegations. Supt. Dimopoulos recalled "there was discussion about capacity with … with SiRT and as well the financial component to the investigation, or potential investigation."[88] He agreed with C/Supt. Leather that any participation by the RCMP in [the investigation of] that referral would be very inappropriate."[89] He suggested that the Toronto Police Service or Ontario Provincial Police "would be better suited to support that investigation, if the decision was made by SiRT to move forward on it."[90]

Supt. Dimopoulos stated that prior to this, he had never been asked to make recommendations to the SiRT regarding how it should proceed in investigating a referral. C/Supt. Leather also stated that this was an "unusual" conversation "but also not unexpected given [SiRT's] resource constraints."[91] He noted that he "had never gone to SiRT in [his] tenure with anything that approached this in terms of the severity or volume, right, in terms of the number of potential witnesses, etc. So it was an anomaly in that sense for sure."[92]

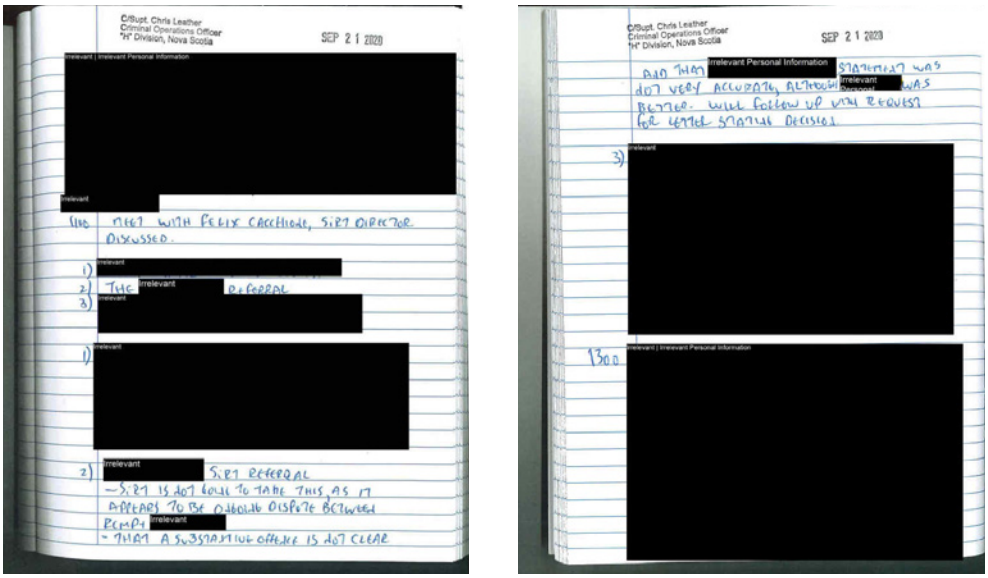
Director Cacchione did not recall the SiRT requesting that the RCMP provide assistance to the investigation. He stated that the SiRT's capacity or resources "may have been a minor factor" in the decision not to proceed with an investigation of the referral.[93]

On July 24, 2020, C/Supt. Leather wrote to Director Cacchione to follow up on their prior conversation about the referral. His email states, "We wanted to follow up on the possibility and scope of any RCMP investigative assistance to the referred investigation."[94] On July 27, 2020, C/Supt. Leather spoke with Director Cacchione again. His notes of the call state in part, "MOU will look into this – billing DOJ" and "not able to assist SiRT witH Divisional resources."[95] He confirmed the thrust of this conversation as follows:

> COMMISSION COUNSEL: So if I understand your evidence so far, July 27th, 2020 – call sound like it's principally about the Director, once again, asking the RCMP for resourcing assistance or funding. You're telling us, I think that's a non-starter, and you told him so, right?
>
> C/Supt. LEATHER: Correct.
>
> ...
>
> Any sort of Support Services, specialized policing, even though we have those resources in "H" Division, if they were going to be forthcoming, they would have most certainly come from another division.[96]

C/Supt. Leather and Director Cacchione spoke on August 5, 2020, and met again on September 21, 2020, to discuss the July 2020 Referral, among other matters. C/Supt. Leather's notes of the meeting record that Director Cacchione advised that the SiRT would not be proceeding with the July 2020 Referral because it appeared to be an "ongoing dispute" between the RCMP and a municipal police agency and "a substantial offence [was] not clear." The notes also state that one of the witness statements related to the referral was "not very accurate," although another witness statement "was better":

> - SiRT is not going to take this, as it appears to be ongoing dispute between RCMP + [redaction]
> - That a substantial offence is not clear
>
> And that [redaction] statement was not very accurate, although [redaction] was better. Will follow up with request for letter stating decision.[97]



C/Supt. Leather's notes of the meeting held September 21, 2020, COMM0065183. (Redactions placed by Attorney General of Canada)

In his Commission interview, Director Cacchione stated that the basis for declining to invoke the SiRT's mandate included his perception that doing so would be putting the SiRT in the middle of a dispute between two police agencies:

> FELIX CACCHIONE: I think it was Chief Superintendent Leather who made the referral and, as I recall, there was, there was a police officer [redactions] who made allegations against a [redaction] member of [redaction]. And what I reviewed was that officer's statement about what the officer alleged they had heard; I don't believe there was first-hand knowledge. And to be quite candid, there seemed to be no love lost between the RCMP and [redaction], and I wasn't going to get in the middle of that and in any way affect the independence of our organization. And as I said before, reviewing what the [redaction] officer, had said, there was no basis to begin an investigation.[98]

Director Cacchione stated that the information contained in the report "was secondhand information" but what "stuck in [his] mind" was his feeling that the SiRT was being "put in the middle of this situation" and he "didn't feel that we should be there."[99] He explained:

> … instead of [the RCMP] investigating it themselves they, because of this, as you've said, turf war, they wanted us to do it. And I wasn't prepared to put us in that position.
>
> …
>
> It all just didn't smell right to me. And I didn't want to get into it.[100]

Director Cacchione stated further: "[T]he report was secondhand, this was, you know, two parties that didn't get along together and one of them didn't want to appear to be pushing the other and wanted us to do it" and "I wasn't prepared to do that."[101]

On October 26, 2020, C/Supt. Leather wrote an email to Director Cacchione, stating, "I confirm that you notified me some weeks ago that SiRT would not be investigating the aforementioned referral completed by H Division to your office related to alleged criminal misconduct …" and "I am respectfully requesting written confirmation of same from your office."[102] C/Supt. Leather explained why he wanted a written decision from the SiRT: "I was looking for something in writing. And, you know, the Director doesn't owe me an explanation, but I think, not I think, he does owe and it's in policy, quite clearly; if they're not going to take an investigation, there needs to be a written decision document or memo that would pertain to that."[103]

Director Cacchione responded to C/Supt. Leather's email on the same day, stating, "My apologies for not confirming in writing that SiRT would not be investigating the above captioned matter."[104] In his interview with the Commission, C/Supt. Leather stated that he did not receive further written correspondence from the SiRT explaining its decision after the October 26, 2020, email. He did not have access to his notebooks from November 4, 2020, onward during that interview. After his interview, the RCMP disclosed an additional letter from the SiRT dated December 17, 2020, addressed below.

On October 30, 2020, H Division sent a further situation report to RCMP national headquarters advising that the SiRT director had confirmed "that SiRT would not be investigating this matter."[105] The situation report states that "[w]ith no criminal investigation being undertaken by SiRT, 'H' Division Senior Management is assessing the option of reporting the potential Police Act violations to the Nova Scotia Office of the Police Complaints Commissioner (OPCC)/Police Review Board" or "Alternatively, a complaint could be made to the [redaction] Board of Police

Commissioners. Further discussions will be had with C&IP [Contract and Indigenous Policing]."[106] The report states further:

> How this information was obtained by the RCMP may be linked to the pending mass shooting public inquiry in Nova Scotia, in relation to the [redaction] issues with [redaction]. "H" Division senior management is discussing whether this information should be held securely by the "H" Division Issues Management Team for examination by the Commissioners if required. Further discussions will be had with C&IP.[107]

Following this report, H Division and RCMP national headquarters representatives had several phone calls to discuss the July 2020 Referral. On November 24, 2020, C/Supt. Leather requested that his assistant arrange a meeting with A/Commr. Bergerman and Director Cacchione "to discuss SiRT's decision not to investigate the referral."[108] On December 16, 2020, C/Supt. Leather met with Director Cacchione regarding the referral. C/Supt. Leather's handwritten notes of the call indicate that "additional interviews [were] conducted by SiRT" and "no evidence of criminality surfaced." They also state, "no file opened/no SiRT investigation."[109] The notes also state, "[d]iscuss conduct issues – decide that" and "matter should be [illegible] to Minister for the New Year."[110]

On December 17, 2020, Director Cacchione wrote to C/Supt. Leather confirming that the SiRT would not be proceeding with the investigation of the referral. The letter states that the SiRT reviewed statements taken by the RCMP in relation to the referral as well as other material, and conducted one witness interview. The SiRT concluded that the information "examined in our review points to this referral being one that does not meet the SiRT mandate but rather one that may be considered by the Policing Services section of the Nova Scotia Department of Justice, if you choose warranted."[111]

In a submission to the Commission, the SiRT explained that, for some complaints, the SiRT takes preliminary investigative steps in order to determine whether the subject matter of the complaint falls within the SiRT's mandate. These files are called "review" files and do not become "criminal investigation" files unless and until the SiRT determines that "the subject matter of the referral involves a serious incident involving the police which may warrant criminal charges and therefore falls within the SiRT's mandate."[112] As set out above, after the SiRT decided not to conduct a criminal investigation, H Division recommended to national headquarters that the matter be considered for referral to the Office of the Police

Complaints Commissioner (OPCC) or municipal police board. However, C/Supt. Leather advised that the RCMP did not make either referral:

> All I can say is that there was no appetite at the Divisional level, the Commanding Officer's office, to do either of those … What discussions were had between [A/Commr. Bergerman] and the [RCMP] Commissioner or the Deputy, I am not aware; I did not participate in those, and I don't recall having any follow-on discussions with [A/Commr.] Daley or [C/Supt.] Rupa either.[113]

Director Cacchione recalled that the SiRT similarly did not report the matter to the OPCC or any other body involved in the oversight of police. He explained that in his experience, when the SiRT received complaints that fell outside its mandate, it would not refer them to the OPCC or the Civilian Review and Complaints Commission (CRCC). The SiRT's practice was to advise complainants that the matter may properly be reviewed by another oversight body but would not itself notify the other oversight body. We note that while the *Police Act* states that the SiRT can refer matters to the OPCC (or the CRCC), the OPCC would not be authorized to investigate such a referral at first instance. Rather, the OPCC could only refer the matter to the chief officer of the agency that was the subject of the complaint (unless the complaint was about the actions of the chief officer). Former interim SiRT director Pat Curran, who is the current police complaint commissioner, stated that, in practice, there is no mechanism for the SiRT to refer matters to the OPCC.

C/Supt. Leather told the Commission that it was of concern to him that the allegations in the July 2020 Referral were never fully investigated: "Of course, they should be of concern to anybody reading this material, myself or anybody doing any sort of analysis that has any understanding of investigations, corruption, and integrity of policing, for goodness' sake. The matter screams for a proper and thorough investigation, to be clear."[114]

The evidence we received regarding the steps taken to report and investigate the July 2020 Referral raises three primary concerns. First, it is concerning that the SiRT may not have pursued an investigation into the information shared by the RCMP about criminal conduct on the part of a member of a municipal police agency because of its apprehension that by pursuing this investigation, the SiRT would be inserting itself into the middle of a dispute among police agencies. The information provided by the RCMP about alleged wrongdoing was specific and included

the name of a witness who was independent of the RCMP. In Part C of this volume, we return to the theme of conflict arising between RCMP H Division leaders and municipal police chiefs and the escalation of that conflict after the mass casualty. For present purposes, we observe that concerns about the effect of an investigation on inter-agency relationships must never be a basis on which the SiRT declines to exercise its jurisdiction.

Second, we understand that after the SiRT declined to conduct a criminal investigation, the matter was not referred to any other body responsible for police oversight. As noted at the outset of this section, after learning this information, Commission counsel brought this matter to the attention of the minister of justice to determine whether additional follow-up is required with respect to the investigation or review of these allegations.

Finally, while the RCMP eventually received a letter stating the SiRT's decision not to conduct a criminal investigation of the allegations, that decision was not publicly reported. As set out above, the SiRT explained that the July 2020 Referral was treated as a "review file" rather than a criminal investigation file. The SiRT does not report its decisions in review files. However, the SiRT does report the total number of review files in a given year in its annual reports. The SiRT's 2020–2021 annual report states that of the 44 files that SiRT opened in the 2020–2021 year, 20 were treated as review files (with the other 24 being investigation files). The annual report identifies the percentage of review files that involved each Nova Scotia police agency but does not provide any further information to the public on these files. As the Tulloch Report observed in relation to Ontario's SIU, the public has an interest in the outcome of these review files. There is no requirement for the SiRT to issue a final report in a review file as it does in investigation files. However, more details about these files should be included in their annual reports. Specifically, in these reports, the SiRT should list the review files from the preceding year and identify in summary format the reasons why the SiRT did not invoke its mandate in each file.

MAIN FINDING

Concerns about the impact of an investigation on interagency relationships must never be a basis on which the Serious Incident Response Team declines to exercise its law enforcement powers.

Concerns that budgetary constraints limit the SiRT's capacity to investigate alleged wrongdoing also arose at numerous points within our process, including with respect to the July 2020 Referral. These constraints arguably also impair the independence of the SiRT, pressing it to rely on the specialist knowledge of the agencies whose members it is tasked with investigating. Budgetary constraints were also cited as a factor that constrains SiRT's capacity to provide more detailed public reports of its investigations. As we explain in more detail in Part C of this volume, public accountability is undermined and potentially defeated when oversight bodies such as the SiRT cannot fully discharge their statutory responsibilities due to budgetary constraints.

LESSON LEARNED

Agencies that investigate alleged criminal wrongdoing by police officers provide a critical law enforcement and public accountability function. They must be adequately resourced and trained to allow them to do their work thoroughly and effectively.

Recommendation P.34

SERIOUS INCIDENT RESPONSE TEAM RESOURCES

The Commission recommends that

The Province of Nova Scotia should undertake a review of the Serious Incident Response Team's budget and staffing complement to ensure it can fully exercise its investigative responsibilities and perform its public accountability function and maximize its contribution to enhanced confidence in policing in Nova Scotia.

Recommendation P.35

SERIOUS INCIDENT RESPONSE TEAM REPORTS

The Commission recommends that

(a) Section 9 of the *SiRT Regulations* should be amended to adopt the language set out in section 34 of the Ontario *Special Investigations Unit Act.* This amendment will ensure that the SiRT's public reports in instances where no charges are laid provide sufficient information to allow the public to understand why SiRT has reached its conclusion and to evaluate that outcome.

(b) Starting immediately, all SiRT reports in which criminal charges are not laid against the subject police officer should be drafted with sufficient detail and analytical transparency to allow the public to understand and evaluate the director's reasoning and conclusions.

Part C:
Reimagining Policing in Canada

CHAPTER 9

What Are the Police For?

CHAPTER 9 What Are the Police For?

Throughout our process, Participants emphasized the trust communities place in police to act effectively to secure community safety. For example, counsel for the Goulet family observed:

> As citizens, we believe that police will stop people from acting on their violent, criminal intentions and protect those who are vulnerable. We assume that our police will act responsibly, timely and effectively as a crucial part of the Canadian justice system.
>
> Most importantly, we place our trust in police to keep us safe.[1]

What we expect of the police depends on our collective answers to the question, "What are the police for?"

Dr. Ian Loader, professor of criminology at the University of Oxford, considers this question in a paper he prepared for the Police Foundation's *Strategic Review of Policing in England and Wales* in 2020.[2] Dr. Loader observes that this question has been asked and answered in a variety of ways over the years, including by those who provide a list "of all the tasks that police are unavoidably called upon to undertake" and those who point, in their answers, to "Peelian principles." Peelian principles are a set of principles for civilian policing that "continue to serve as a key reference point for thinking about the fundamentals of modern policing." These principles were a staple of policing textbooks in the United Kingdom, Australia, and Canada in the 20th century, setting out an idea of policing by consent and co-operation with the public.[3]

Peelian principles focus on the public legitimacy of police; the use of crime prevention and impartial application of law in preference to the use of force; no favour or vengeance in response to wrongdoing; and the role played by police in relationship with the communities and legal systems of which they are part. Peelian principles

are embraced by Canadian policing scholars. For example, Professor Kent Roach, from the University of Toronto Faculty of Law, suggests these principles are "very helpful as aspirations for public policing … [T]hey provide a glimpse of common ground that could convince both policing leaders and the police rank and file that policing needs to change to better respect and serve the public."[4] Peelian principles set out worthwhile aspirational values for the present and future – although, as Professor Roach and Dr. Loader observe, they require updating to reflect social and legal norms with respect to equality and non-discrimination.[5]

However, as Professor Roach also explains, Peelian principles do not reflect Canadian policing history, particularly that of the RCMP: "In Canada, we have never fully accepted civilian policing. The settlers started with paramilitary and colonial policing. This caused much damage, especially to Indigenous people, but ultimately to all who are policed by force and intimidation."[6]

Professor Colleen Bell, at the University of Saskatchewan, and Kendra Schreiner, of the London School of Economics, have described the role the RCMP played in "sovereignty and territorial acquisition and Indigenous repression" after Canada's dominion status was conferred.[7] The RCMP's role in enforcing Canada's residential schooling policy against Indigenous children was documented by the Truth and Reconciliation Commission, which noted in its final report that for "many Aboriginal children, their first encounter with the justice system came when an RCMP officer appeared in their community to take them to residential school."[8] As these two examples demonstrate, the Peelian notion of policing by public consent and co-operation was not, historically, central to Canadian policing. This history remains important, in part because "the track record of past police behaviour forms a legacy acting on public confidence towards the police today."[9]

In his 2020 paper, Dr. Loader suggests that the Peelian principles do not provide a satisfactory answer to the question, "What are the police for?" He argues that the Peelian principles do not function as a critical yardstick for public legitimacy, and that they instead "operate as a substitute for thought about that question, not as resources for thinking." He explains that "[k]eeping that question in play, and subject to public discussion, is essential both to the effectiveness and legitimacy of policing, and to the quality of democratic life."[10] Dr. Loader sets out four reasons for thinking carefully about what police are for:

1. Police exercise force over community members, and such use of force should be subject to a "skeptical watch" on the part of the community, particularly

about "how, under what conditions, and against whom coercion is used" by police;

2. "[P]olice make use of scarce public funds which can always be used in other – maybe better – ways." It is therefore appropriate to keep track of police use of funding and to ask questions about whether police funding can be better used to support other front-line agencies or "wider investments that foster and sustain secure and cohesive societies";
3. Policing happens amid changing contexts, which include "the wider picture of socio-economic division, political contestation and technological change that shape patterns of harm and demands for policing." Dr. Loader argues that we "need to revisit" the question, "What are the police for?" in light of these changing contexts; and
4. "[T]here is no 'policing solution' to the problem of what makes societies secure and orderly. Given this, attention to the police role must be alive to the question of how the police fit into this broader landscape of pluralised policing and harm prevention."

Dr. Loader argues that "[t]he problem of the police mission needs constant attention. It is wrapped up with the question of how we govern the police and determine how and what the police can contribute to the production of safe, cohesive and just societies."[11] He emphasizes that the work police do to contribute to public order is shaped by the social context, and that to a large extent this social context is not of the police's making: "[t]he more structural inequality and exclusion a society produces, the harder and more conflictual the police task becomes."[12]

The question, "What are the police for?" has also been considered by those who have called to defund or detask the police. In January 2022, a community advisory committee established by the Halifax Board of Police Commissioners presented a report on *Defunding the Police: Defining the Way Forward for HRM* (Halifax Regional Municipality). This report explains: "In the most basic sense, defunding is in part exactly what it sounds like: removing money from the police. More broadly, it is part of a discussion about reimagining public safety and moving away from relying on policing and punishment to solve social problems."[13]

Closely associated with the work of Black and Indigenous scholars and activists, the defund conversation invites the community, at a minimum, to consider what functions are presently being performed by police but may be better situated

elsewhere. In order to answer these questions well, it is necessary to think and talk about what the police are for.

Our Commission was established to examine police work before, during, and after the mass casualty of April 18 and 19, 2020. This incident, and the police responses to it, played out in a context of declining public trust in Canadian policing and other government institutions. Throughout our work, we heard from community members and families most affected, Participants, and members of the broader public that the mass casualty and its aftermath had caused them to question their former trust in Canadian police. The following quotation from counsel for the Goulet family is illustrative:

> For many families, including the Goulet family, the lack of answers and lack of attention from the RCMP and from government agencies increased their hurt and confusion, and led to anger, disillusionment, and a complete loss of trust in the institutions that we count on to keep us safe, to guide us in times of loss and tragedy, and to give us answers.[14]

Another Participant counsel stated:

> [I]n this case, a cascade of failures, errors and missteps by the RCMP fundamentally impacted the trust Nova Scotians have in the RCMP to maintain public safety.[15]

The ripple effect from the mass casualty can be seen in the following quotation from a community member who had a professional role in its aftermath:

> I was driving to my daughter's hockey game a couple weekends ago and I was driving from Dartmouth to Pictou. And it was like a traffic stop. He was just pulling people over, you know, very well intended …
>
> So my daughter, who is 10 now, obviously heard some things that I wish that she wouldn't have heard – overheard on telephone conversations, so when the police officer pulled me over, she panicked. And she didn't panic because we were being pulled over. She panicked because he was an RCMP officer.[16]

We heard from others that their trust in police was already low, and that they have experienced the police as a threat to their sense of community safety and

well-being, rather than as protectors of those things. As we explain in Volume 3, Violence, a Participant in our process, Avalon Sexual Assault Centre, held engagement meetings in September and October 2022 to hear from survivors impacted by the perpetrator. The consequent Avalon Report provides examples of community mistrust in police with respect to Indigenous Canadians and African Nova Scotians:

> [H]ow an institution interacts with members of marginalized communities has impacts beyond the specific individual engaging with the institution. In rural Nova Scotia, for example, African Nova Scotian women have expressed negative perceptions of police grounded in the negative experiences of the African Nova Scotian men and boys in their lives. They did not feel the police protected them, and did not trust police.
>
> Many Indigenous people in Canada recall watching the negative interactions their parents and grandparents have had with police in the past when attempting to report a crime … This in turn affects the trust they have that the police will take their report of experiencing violence seriously in the future.[17]

We also heard that the RCMP's failure to take accountability for their work during and after the mass casualty has further eroded the trust of African Nova Scotian communities. Crystal John, an African Nova Scotian woman and social worker at Adsum for Women and Children in Halifax explained:

> [W]e've always had a strained relationship with law enforcement, and you know, it's been steeped in racism throughout our history, and the false narrative of even the mass casualty has a way of kind of further damaging and confusing the idea of safety for African Nova Scotians because, you know, we already have a very precarious relationship with law enforcement and now this false narrative gives a sense of "Who can we trust. Will it happen again?" … [I]t does bring up trauma from past as well in in our communities.[18]

Our analysis of the police work done before, during, and after the mass casualty demonstrates that public trust is integral to the police's capacity to do their work effectively. Public trust is, in turn, affected by public conversations about how

well the police do their work, and by how police agencies respond to those public conversations. As Dr. Loader suggests:

> [I]f one conceives of policing as playing a small but vital role in sustaining secure belonging, and as requiring the equal voice of all affected by it, such inclusive deliberation [about what the police are for] is best seen as a formative part of the police mission, not as a distraction from core tasks. Democratic mediation of demands for order and protection is a practice we should be looking not to scale down or marginalise, but to deepen and extend.[19]

In a paper published in 2016, Dr. Loader proposed eight principles that constitute an update to the Peelian principles. He argued that these principles are sufficiently specific to guide regulation of policing and sufficiently attentive to the range of functions performed by police to provide an adequate platform for regulation. These principles are outlined in the text box below.[20]

Loader's Principles of Policing

1. The basic mission of the police is to improve public safety and well-being by promoting measures to prevent crime, harm and disorder.
2. The police must undertake their basic mission with the approval of, and in collaboration with, the public and other agencies.
3. The police must seek to carry out their tasks in ways that contribute to social cohesion and solidarity.
4. The police must treat all those with whom they come into contact with fairness and respect.
5. The police must be answerable to law and democratically responsive to the people they serve.
6. The police must be organized to achieve the optimal balance between effectiveness, cost-efficiency, accountability and responsiveness.
7. All police work should be informed by the best available evidence.
8. Policing is undertaken by multiple providers, but it should remain a public good.

Dr. Loader explains the aspirations that underpin these principles:

> They aim to describe, and bring into clearer view, police organizations that are democratically accountable, attuned to good evidence about effective practice, and oriented to articulating and serving the common good rather than sectional interests. These principles project a vision of a police service with a social purpose that combines catching offenders with collaborative work to prevent harm and promote and maintain order in communities. They propose a police service that listens closely to the demands of all citizens while directing scarce resources towards meeting [the] needs of the most vulnerable. They anticipate a police force subject to much stronger forms of citizen oversight, accountability … a force that is "compelled to describe what they are doing as they govern us.[21]

While some of the fundamental features of a policing system that follows these principles are already in place in Canada, there remains much work to be done. We begin in this chapter with a discussion of the police role in fostering community safety. In Chapter 10, we set out recommendations for reform to the RCMP and its governance that will help to ensure that their future work better reflects these principles. In Chapter 11, we discuss how these principles should be engaged within a conversation about the future of policing in Nova Scotia. We return to these principles in Part D, in the context of a discussion of everyday policing practices.

LESSON LEARNED

Police agencies should be democratically accountable, attuned to good evidence about effective practice, and oriented to articulating and serving the common good. They should combine law enforcement with collaborative work to prevent harm and promote and maintain community safety. They should listen to the demands of all citizens, while directing resources toward meeting the needs of the most marginalized members of our communities. They should be subject to strong forms of government and citizen oversight and accountability.

Recommendation P.36

PRINCIPLES OF POLICING

The Commission recommends that

All levels of government and Canadian police agencies adopt the following principles of policing, as framed by Dr. Ian Loader, "In Search of Civic Policing: Recasting the 'Peelian' Principles" (2016):

1. The basic mission of the police is to improve public safety and well-being by promoting measures to prevent crime, harm and disorder.
2. The police must undertake their basic mission with the approval of, and in collaboration with, the public and other agencies.
3. The police must seek to carry out their tasks in ways that contribute to social cohesion and solidarity.
4. The police must treat all those with whom they come into contact with fairness and respect.
5. The police must be answerable to law and democratically responsive to the people they serve.
6. The police must be organized to achieve the optimal balance between effectiveness, cost-efficiency, accountability and responsiveness.
7. All police work should be informed by the best available evidence.
8. Policing is undertaken by multiple providers, but it should remain a public good.

These principles should govern how police do their work and how they are accountable for the work they do.

The Police Role in Fostering Community Safety

Parts C and D of this volume are the culmination of the Commission's efforts to gather the lessons that have emerged about policing from the perpetrator's history of violence and misdealings, the mass casualty of April 18 and 19, 2020, and the police responses to these happenings. We also attend carefully to what we learned, and documented in Part B of this volume, about how police in Nova Scotia and at RCMP national headquarters responded to public scrutiny of and concerns about their work in the days, months, and years after the mass casualty. We place our findings into the context of a history of Canadian reports about police operations, police governance, and police accountability to the communities they serve.

As we explain in Volume 7, Process, **when we began our work we were conscious of the many reports that had been written in Canada on subjects engaged by our mandate, including Canadian policing. Rather than seeking to replicate that work, we captured and built on it by looking closely at the findings and recommendations of past inquiries and the efforts made to implement those recommendations.** Our focus on the lessons learned by government agencies from past reports, and on the efforts made to implement and sustain this learning, became a central feature of our work and a core focus for Participants. For example, one Participant counsel submitted:

> 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 …
>
> The evidence before the Commission supports a reasonable conclusion that recommendations flowing from a variety of past RCMP Reviews, Reports, Inquiries, and Investigations have had challenges with implementation and execution.[22]

Throughout this Report, we have discussed past recommendations and their implementation, or lack thereof. In this Part, we continue this approach and also provide a more detailed analysis of what we have learned about the RCMP's governance,

democratic accountability, and management culture, including its approach to implementing change.

The Mass Casualty Commission is different from past inquiries in significant ways. Our joint federal-provincial status gave us the capacity to look closely at the role and contributions of both these levels of government. For example, we could exercise subpoena powers against federal and provincial institutions. This is an important power given that policing in Canada is largely a provincial responsibility, with a significant proportion of policing services being delivered by the RCMP, which is a federal agency. Some past inquiries have found it difficult to obtain a full picture of the manner in which the RCMP delivers contract policing services in the provinces and territories because of the constraints imposed by constitutional federalism.

The subject matter of our inquiry is also distinctive. Canadian inquiries and independent reviews have previously considered aspects of the operational work of police, including the policing of protest movements, particular police investigations, and police conduct. In some instances, the question of whether the police should play a primary role, or if the public response should come from another agency, forms part of the conversation. For example, this debate arises with respect to policing Indigenous protests and police responses to community members who experience a mental health crisis. However, Canada has not seen any prior independent review of or inquiry into the police response to a mass casualty incident and its antecedents. The specific factual context of the Mass Casualty Commission adds to the work and insights of past independent reviews. Recognizing violence and, when necessary, responding to violence – including potentially with a use of force – is, on any view of the matter, one of the core functions of the police and fits squarely within the answer to the question, "What are the police for?" In Volume 3, Violence, and Volume 4, Community, we described the importance of adopting a prevention-oriented public health approach to violence. Within such an approach, police would embrace modernized education and procedures that prioritize a proactive consideration of how best to prevent violence over a reactive assessment of whether a chargeable offence has occurred. Establishing a shared understanding of the police function and the limits of the police role will help to ensure that the entire community safety ecosystem functions effectively.

As Dr. Loader observes, the stereotype of police work as being dominated by direct engagement in crime fighting is a radical misunderstanding of the nature of everyday policing. However, this stereotype has a cultural resonance that reflects a tacit acknowledgment that "what simultaneously justifies and delimits police

intervention in social relations is their unique capacity – when required – to wield non-negotiable force" to enforce community security on behalf of the community.[23] **If police are differentiated from other public services primarily by this permission to use force, when necessary, against community members, then it is crucial, as a matter of democratic oversight, to scrutinize when, how, under what conditions, and against whom they use force, and to assess how effectively they perform this core role when force is required. Considering our context more specifically, we know that RCMP members pursued a heavily armed perpetrator across a significant portion of rural Nova Scotia. That perpetrator killed 22 people, one of whom was expecting a child at the time she was killed, and physically injured three others before being killed by police. The community has a legitimate interest in understanding how well the RCMP prepared for and discharged this responsibility, and how they accounted to the community for their work.**

Although the permission to use force when necessary differentiates police from other public agencies and contributors to community safety, the use of force is – and must remain – exceptional. The police are also "for" investigating alleged wrongdoing fairly and in accordance with the law, and for creating documentation that allows police and other organs of the legal system to do their work.

In exercising all these functions, including the use of force, the police have the capacity to contribute to a shared, democratic sense of belonging – or to undermine that sense:

> The contribution police make to security is deep in so far as police behaviour can and does provide individuals with a powerful token of their membership of a political community in ways that afford them the practical and symbolic resources required to manage, and feel relatively at ease with, the threats they encounter in their everyday life. If one doubts this, think of the difference between a victim of domestic violence or "hate crime" confronted by a police force that treats such violence as "rubbish work" and one that publicly and through its actions treats the problem as serious crime. Policing, in this respect, is never simply an answer to the question "How safe am I?" The police also, in a limited but profound way, help individuals to answer such questions as "Where do I belong?" and "Who cares about me?" By supplying affirmative answers to such questions, the police perform vital security-enhancing work.

> The police contribution to security is "narrow" in so far as it does not require officers to be supplied in ever greater numbers, or be displayed in front of, or known by, the citizenry. Rather, that contribution flows from a tacit, confident assurance that the police can be called upon to recognise and respond to public concerns in ways that demonstrate that they are answering to priorities that have been democratically negotiated by all affected communities (thereby taking seriously the problem of latent demand) and respect the rights and minority interests that constitute a common democratic culture. By so doing, the police supply people with a sense of shared identity and secure belonging. In other words, police contribute to security in a democracy as – and by remaining – constrained, reactive, rights-regarding agencies of minimal interference and last resort repair.
>
> The maintenance of a universal, fair and effective response to calls for attention is arguably a litmus test of this conception. The capacity of all affected by harm or disorder to summon the police when they are threatened or violated and have the police come to their aid without fear or favour, is a significant, hard-won and fragile historical achievement, as well as a telling indicator of social solidarity … **Having the police come when they are called sends a powerful signal that the state cares and contributes enormously to the lived experience of secure belonging. The police may in most instances be able to do no more than apply provisional solutions to deep-seated or wicked problems. But the fair application of such solutions makes a vital contribution to people's security.**[24]

We take seriously Dr. Loader's propositions that police can make a crucial contribution to community safety and to community members' sense of belonging, and that the conditions in which police make this contribution reflect wider policy choices that are largely outside their control. In Parts C and D of this volume, we consider how the answers we give to the question of what the police are for can help to guide conversations about police culture, accountability, and education. Throughout, we centre our analysis on communities, democratic principles, and accountability.

CHAPTER 10

A Future for the RCMP

CHAPTER 10 A Future for the RCMP

In this chapter, we take stock of what we have learned about the present state of the RCMP's management culture and operational effectiveness, as a starting point from which we point toward a proposed future for the RCMP.

Management Culture

By management, we refer to commissioned officers, which in the RCMP means those sworn members who hold the rank of inspector, superintendent, chief superintendent, assistant commissioner, deputy commissioner, and commissioner. We also include civilian employees who hold equivalent ranks or leadership positions – for example, the chief human resources officer, chief strategic policy and external relations officer, and chief financial officer, all of whom sit on the RCMP's Senior Executive Committee with the RCMP commissioner and five deputy commissioners.

The term "culture" refers to the individual attitudes, values, legitimated standards, and norms that are evident within a given milieu – in this instance, among RCMP management. Anthropologists suggest that culture is best understood as a practice. This understanding can be achieved "by examining the various ways in which [culture] is used as though a tool" by members of the milieu to make sense of their work and experiences.[1]

The term "management culture" should not be interpreted to suggest that all RCMP managers have the same background, training, or attitudes, or that they approach their work in the same way. To the contrary, attention to management culture is particularly important in moments when members of RCMP management have conflict with one another.

We conclude that despite efforts to reform the RCMP and its organizational culture, problems identified by past commissions and reports persist within the institution. Past inquiries have concluded that these problems create a toxic workplace culture within the RCMP. We find that they also impede the RCMP's operational effectiveness.

This Commission proceeded at the same time as a broader Canadian conversation was playing out about the RCMP's role in providing front-line policing services in particular communities. While noting that many Canadian jurisdictions are now engaged in conversations about whether to continue acquiring policing services from the RCMP, we are also conscious that the RCMP will continue to provide contract policing services in Canadian communities for the foreseeable future. We believe that how the Government of Canada and the RCMP respond to the recommendations we make in this Report could have a significant bearing on the future of the RCMP's contract policing services.

An overwhelming recurring theme of past inquiries and reports about the RCMP is the organization's incapacity to respond quickly, publicly, or effectively to acknowledge, seek to understand, and rectify its mistakes or shortcomings. This tendency was also evident in our process. In this chapter, we make recommendations for reform of the RCMP with respect to its democratic accountability; contract policing; rural policing; recruitment, education, and research; and management culture. Parliament, the RCMP, and Public Safety Canada must act decisively to implement our recommendations in these areas if the RCMP's contract policing business line is to have a future in providing the democratic, rights-responsive, equality-regarding police services that Canadians rightly expect.

Taking Stock of the Present

Throughout this Report, we have documented shortcomings in the RCMP's work and organizational effectiveness. The RCMP failed to recognize, document, and act on community concerns about the perpetrator's violence and unlawful possession of firearms. Despite the lessons offered in the report written in 2014 by a retired assistant commissioner of the RCMP, Alphonse MacNeil, in response to the mass casualty in Moncton, New Brunswick, the RCMP failed to prepare systematically

or train its supervisors, public communications staff, and Operational Communications Centre employees for a complex mass casualty incident in rural Canada. After the mass casualty, the RCMP failed to communicate effectively or candidly with a shaken public. It did not make sustained efforts with its employees to gather the lessons that emerge from the April 2020 mass casualty or to provide information, care, or adequate support to victims, families, and RCMP employees who had suffered harm.

Widening the lens, we see that these failings were not unique to this perpetrator or this critical incident. Past reviews have documented other instances of similar shortcomings. These reviews were further reinforced by evidence given by Participants and roundtable members – for example, the information shared in the report *We Matter and Our Voices Must Be Heard*, prepared by the Avalon Sexual Assault Centre, and our analysis of the RCMP's response to complaints of sexual and gender-based violence made by Susan (Susie) Butlin before she was murdered in 2017 by her neighbour. The evidence suggests that the RCMP does not always respond adequately to reports of gender-based violence and that some community members – particularly members of marginalized communities – do not trust the RCMP or other police services. These reviews and this evidence also suggest that the RCMP does not have effective institutional processes in place to ensure that individual members and the organization as a whole can learn from past mistakes.

In our process, it was apparent that the organizational structure of the RCMP both contributes to these failings and makes it challenging to hold the organization accountable for its work. In the words of one Participant counsel:

> **It appears that the management structure of the RCMP, from an outsider's perspective, is this incomprehensible web that actually thwarts efforts to hold the RCMP accountable and thwarts the RCMP's own efforts to change. And what I'm referring to is if I had a dime for the number of times I have heard an RCMP officer say, "Not my department." "Can't answer that question." "Not sure." "You need to ask this person."**[2]

In the words of another Participant counsel:

> We were continually astounded by the number of times officers … 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.**[3]

We too found it difficult at times to build a clear picture of the organization's decision-making, roles, and responsibilities. These challenges are reflected, for example, in Part B of this volume, in our assessment of the evidence we heard about the fate of the RCMP's proposed after-action review and about coordination challenges arising in the organization's internal briefing practices after the mass casualty. We have also documented gaps and overlap in the enormous volume of RCMP policy documents we received – for example, in Part A of this volume with respect to critical incident response, and in Part B regarding public communications.

This picture was further complicated by uncertainty about the status of guidance documents such as *C3 – Command, Control and Communications: Response and Planning Guide*, produced by officers in the RCMP's Atlantic Regional Council of Criminal Operations in 2015, but not widely known or read, and by the RCMP's failure to maintain current emergency operational plans or standard operating procedures or to ensure that relevant personnel were aware of those plans that did exist. RCMP witnesses, including senior leaders, frequently expressed uncertainty about policy requirements, and some told us candidly they had not consulted RCMP policy to ascertain their responsibilities when performing a given role.

It frequently emerged that senior RCMP witnesses had not been briefed on the evidence before the Commission. For example, counsel for the Goulet family described to Commr. Lucki a number of failings in the RCMP's work with respect to the death of Gina Goulet and the experiences of the Goulet family with the RCMP after the mass casualty. These matters, which are discussed in Volume 2, What Happened, were well established within the evidence and were not contested by the RCMP. Nonetheless, it was evident that Commr. Lucki had not been informed of them. Ultimately, counsel and Commr. Lucki had the following exchange:

> PARTICIPANT COUNSEL: **Nova Scotians are looking for some accountability, and I would suggest to you that the first step is acknowledging, for the RCMP to acknowledge incidents where their actions did not meet the expectations** … And I'm putting it to you, the RCMP Commissioner, I understand that underneath that we have policy, we have everything else, but you answered that you appreciate that – that your members' actions did not meet the expectations of my clients.

> My question was did they meet the expectations of you, as the Commissioner of the RCMP?
>
> COMMR. BRENDA LUCKI: Again, I'm not here to protect, defend my members, but I'm kind of a fact gal. I kind of – I like to have all the – all the information. But it doesn't appear that they have met some of the expectations. If how you say it is exactly how it happened, without all the, you know, the overlying, because I'm sure there's a lot of details to all of that, it doesn't appear that they met my expectations.[4]

Commr. Lucki was evidently not briefed on this evidence before testifying, which meant that the opportunity for the RCMP to more fully acknowledge and accept accountability for these failings was lost. **This instance is a particularly striking example of RCMP senior management's failure to "brief up" and to ensure that its leaders are fully equipped with the information that will allow them to address organizational shortcomings.**

We regard this example as an organizational failure and a reflection of poor briefing practices – it is evidence of the RCMP's persistent cultural aversion to conducting candid internal evaluations of its performance on matters of public concern. This cultural aversion has been documented in other reviews of the RCMP, most notably in *Rebuilding the Trust: Task Force on Governance and Cultural Change in the RCMP*, the 2007 report by David Brown and his colleagues which concludes after extensive consultations with employees that the RCMP's paramilitary culture stifles honest reflection:

> We have observed a number of attitudes and values in the RCMP that affect the way in which decisions are made. For example, we heard more than once that the culture is one of fear and intimidation and that some who are in a position of command use their authority to intimidate others. This has several results. **Employees who are concerned about being criticized would prefer to do nothing – or to pass responsibility on to someone else – rather than make a decision which could attract criticism. It also means that bad news does not travel up in the organization.** Senior management is not in a position to address developing problems because they are insulated from them by people who do not want to deliver bad news. We agree with the sentiment expressed by former Commissioner [Beverley] Busson that the only thing worse than getting bad news is not getting it![5]

The Brown Task Force identified a number of "structural barriers to effective management" in general and specifically in the RCMP's contract policing services. In our process, we observed the continued operation of the management culture described by Mr. Brown, particularly at moments when senior RCMP leaders could not explain decisions or institutional activities that seemingly fell within their purview. Examples of this dynamic may be found in Part A and Part B of this volume. The Participant quotes above show that they, too, were troubled by the ways in which the RCMP's management structure made it difficult to identify clear lines of authority and accountability.

By the end of our process, the RCMP and individual RCMP witnesses had acknowledged some shortcomings in the critical incident response of April 18 and 19, 2020, and in the RCMP's subsequent public communications and community work. Some pointed to learning that had emerged "instinctively" from reflection on the RCMP's response to the mass casualty. Counsel for the RCMP identified some matters that have been addressed, and we have documented these efforts in this Report.

Some RCMP witnesses took the opportunity to apologize in public proceedings. For example, C/Supt. Darren Campbell concluded his testimony with the following emotional remarks:

> I know that there are a very few family members that are in attendance, but I would imagine that many are watching or monitoring the proceedings. I want to express my sincere condolences and I apologize for failing. I haven't cried for two and a half years. And I'm truly sorry that we failed you and I promise that we'll do better.[6]

However, the RCMP has not apologized for the shortcomings in its work in relation to the mass casualty or its antecedents and aftermath. To the contrary, as we document in Volume 2, What Happened, and in Part B of this volume, its senior management response to difficult questions and public criticism was more often characterized by denial or deflection. This impulse created mistrust among family members of those whose lives were taken, within the most affected communities, and in the broader community. In addition, RCMP senior management's resistance to acknowledging error presents an impediment to institutional learning. Dr. Bethan Loftus, senior lecturer of criminology and criminal justice at Bangor University in Wales, explains in her expert report that "a key obstacle to experience-based learning stems from the dominance of professionalism – notably, the idea

that the police should not make mistakes. If police organizations want to learn and improve, then they need to 'normalize their view of human errors and incidents.'"[7]

We note that the Nova Scotia *Apology Act*, 2008 c 34, permits anyone to apologize "in connection with any matter" without making an express or implied admission of fault or liability, or otherwise adversely affecting their legal position.

In our process, family Participants and community members took note of the RCMP's evident reluctance to acknowledge errors. Richard Ellison, a resident of Portapique, is the father of Corrie Ellison, who was killed by the perpetrator on April 18, 2020. His surviving son, Clinton Ellison, hid terrified in the woods in Portapique for several hours while Mr. Ellison called 911 to seek help for him, until, finally, the Emergency Response Team extracted Clinton – and handcuffed him in the process. The next morning, Mr. Ellison was inside the Onslow Belmont Fire Brigade hall during the Onslow fire hall shooting. In his words: "I never got any, any calls from the RCMP or nothing, saying you know we're sorry about your son and what happened, just nothing."[8]

Participant Tara Long reflected specifically on the opportunity offered by the Commission process to the RCMP:

> [I]f ever there was a forum for people to actually stand up and say, like, dude, I screwed up. I am not going to be punished for it but I, you know, have a guilty conscience for, you know, not doing my job the best I could. Or whatever the case is. I don't know. I wasn't there but I mean, there is a lot of problems. You know, if you just assume that people screwed up. I mean, I screw up all the time. You just have to stand up and say, I did that and, you know, I am accountable. Being accountable for what they did or didn't do when they should have.[9]

As Ms. Long acknowledged in her remarks, mistakes are inevitable. They will happen again. But the RCMP will not regain public trust unless it learns how to say sorry and how to take meaningful steps to be accountable for its errors.

LESSON LEARNED

Police agencies and police officers must be capable of acknowledging and taking responsibility for their mistakes.

Recommendation P.37

TAKING RESPONSIBILITY

The Commission recommends that

(a) The RCMP adopt a policy of admitting its mistakes, accepting responsibility for them, and ensuring that accountability mechanisms are in place for addressing its errors. This policy should apply at every level of the institution.

(b) The demonstrated capacity to accept responsibility for one's errors should be a criterion for any promotion within the RCMP.

As our Commission proceeded, some Canadian provinces were actively engaged in conversations about the future of the RCMP's contract policing services. Reports about police services in British Columbia, Alberta, and the Surrey municipality in the BC Lower Mainland[10] have fostered active debates about the future of RCMP policing services in these jurisdictions. *Defunding the Police: Defining the Way Forward for HRM*, the 2022 report of the Board of the Police Commissioner's Subcommittee in Halifax Regional Municipality, notes that the Halifax Regional Council is reviewing the integrated model of policing services delivered by Halifax Regional Police and the RCMP in that municipality. An August 2011 report, *Sharing Common Ground – Final Report: Review of Yukon's Police Force*, has led to greater community involvement in the RCMP's delivery of policing services in Yukon. Questions about the RCMP's democratic accountability to and relationships with the communities it serves, its model of contract policing services, its standards of education and training, and its management culture lie at the heart of these conversations. In the balance of this chapter, we present our recommendations with respect to these issues.

As we explain in Chapter 11, **we suggest that Nova Scotia, too, should embark on a broad participatory conversation about whether the RCMP will continue to provide provincial policing services to the province. Individual municipalities and First Nations may also engage in similar processes. Regardless of the outcome of that conversation, however, the RCMP will continue to provide contract policing services in Canada for the foreseeable future. The recommendations set**

out in this chapter are the minimum reforms that we consider necessary to allow the RCMP to rebuild public trust and deliver effective, rights-regarding contract policing services in Canadian communities.

Democratic Accountability

In his 2007 *Report of the Ipperwash Inquiry*, Commissioner Sidney B. Linden sets out a basic principle of democratic policing:

> Canadian democracy depends on the ability of the police to fulfill their responsibilities to keep the peace and enforce the law equally, fairly, and without partisan or inappropriate political influence.
>
> At the same time, the police must be responsible and accountable to the public through elected representatives. Governments, legislatures, and the public all have a legitimate interest in the policies and performance of the police. Subject to some important exceptions, all [Canadians] have a general right to know what the police are doing and why.[11]

Police perform a critical role within Canada's democracy, and they must be responsible and accountable to the Canadian public for the manner in which they do their work. The Ipperwash Report provides a detailed description of the requirements of democratic accountability and, in particular, of the tensions that can arise between police claims to operational independence and legitimate public expectations that police and government will be accountable to them. The Ipperwash Inquiry examined the circumstances that led to the police shooting of Dudley George, an Anishinaabe man, during the occupation of a provincial park that was claimed as a sacred site by members of the Kettle and Stony Point First Nation. Its mandate extended to investigating allegations that Ontario politicians and their political staff had interfered with the Ontario Provincial Police response to the protest. Commissioner Linden observes in his report, "[A]bsent constructive reforms, allegations of political impropriety and partisan policing will very likely remain a frequent feature of politics in … Canada."[12]

The Ipperwash Report focuses on the Ontario Provincial Police and its relationship with the Ontario government. However, much of Commissioner Linden's analysis is relevant to the RCMP and its relationship with the Government of Canada. In our work, concerns about police / government relations were evident in some of the commentary offered by RCMP members and Participants about the April 28, 2020, teleconference meeting in which Commr. Lucki expressed her frustrations with H Division's public communications about the mass casualty (see Part B of this volume). These concerns were also raised with respect to Commr. Lucki's acknowledgement of systemic racism, which some RCMP members criticized as a product of undue political influence on Commr. Lucki by Prime Minister Justin Trudeau.

In this section, we adapt Commissioner Linden's analysis of the core tenets of police operational responsibility and ministerial responsibility as the basis for our recommendations for amendments to the *Royal Canadian Mounted Police Act*, RSC 1985, c R-10 (*RMCP Act*). If fully implemented, these recommendations will reduce the frequency of public controversy about government relations with the RCMP by more clearly setting out the respective responsibilities of the RCMP and the minister of public safety. They will ensure that ministerial directives to the RCMP commissioner and exchanges of information between the RCMP and its responsible minister are appropriately documented, and they will clarify who can appropriately give direction to the commissioner. In addition, we anticipate that implementing these recommendations will promote understanding of these roles and responsibilities by the public, members of the RCMP, and ministerial staff.

Finally, these recommendations will codify the democratic principle that the responsible minister is accountable for acquiring and publicly sharing information about the RCMP and its operations. As Commissioner Linden observed, "Ministerial responsibility is not a legal technicality. It is crucial in ensuring democratic accountability for police actions."[13] By emphasizing ministerial responsibility, these recommendations will increase the amount of information that is publicly available about the RCMP and its policies and operations.

These recommendations turn on the fundamental principle Commissioner Linden articulates in his report:

> [D]emocratic government and ministerial accountability depend on the responsible minister's having a very expansive authority to ask questions about police policies and operations. Subject to very limited exceptions, I believe that this authority should extend to being informed of

> any operational matter, even one involving an individual case, if it raises important questions of public policy. In this respect, I agree with the Patten Report that "the presumption should be that everything should be available for public scrutiny unless it is in the public interest – not the police interest – to hold it back."[14]

In particular, Commissioner Linden rejects the suggestion that ministers should be "buffered" from information during a crisis: "[T]here is a danger that the buffer concept, when applied to ministers, could run counter to the principles of ministerial responsibility and accountability."[15] That said, Commissioner Linden concludes that a critical incident commander should "generally be buffered and protected from direct knowledge of discussions within government which might affect or evaluate operational performance."[16] We would add that Major Crime Unit investigators should be similarly buffered from direct knowledge of government discussions while an investigation is ongoing.

Commissioner Linden's conclusion may appear surprising to those who hold an expansive understanding of the principle of police independence. Dr. Philip Stenning, a professor of the Criminology Department at Griffith University in Australia, explains in one of his publications:

> This concept of police independence has been described in various ways, and with varying expansiveness, in common law jurisdictions such as Canada, Britain, and Australia over the years. All the descriptions of it, however, express a similar idea: that there are certain kinds of policing decisions with respect to which it is improper for elected political authorities (such as government ministers or other police governing authorities) to give, or for police to accept from them, any direction or control, or even significant influence or input. Some versions of the "police independence doctrine" go even further than this to assert that, besides being immune from political (governmental) direction on these matters, the police are also not accountable to or through such elected political authorities for such matters.[17]

The report from the Royal Commission of Inquiry into Certain Activities of the RCMP, led by Commissioner David McDonald in 1981, rejects the expansive view of police independence:

> We take it to be axiomatic that in a democratic state the police must never be allowed to become a law unto themselves …
>
> The concept of independence for peace officers in executing their duties has been elevated to a position of paramountcy in defining the role and functions of the RCMP, thus setting the norm for all relationships between the government and the Force. We believe, on the contrary, that the peace officer duties of the RCMP should qualify, but not dictate, the essential nature of these relationships. The government must fulfill its democratic mandate by ensuring that in the final analysis it is the government that is in control of the police, and accountable for it.[18]

The McDonald Commission was established after illegal activities performed by the RCMP during the 1970s came to light. Its report also emphasizes the principle of ministerial responsibility, concluding that the responsible minister has "not only the right to be kept sufficiently informed but the duty to see that he is kept sufficiently informed."[19]

The question of governmental relations with police also arose in the 1989 Marshall Inquiry: Royal Commission of Inquiry on the Donald Marshall, Jr., Prosecution. In that report, which focuses on the wrongful conviction of Mi'kmaw man Donald Marshall Jr. and the administration of criminal justice in Nova Scotia, the Commission found that the RCMP had refrained from pursuing criminal investigations into two members of the Nova Scotia government after a deputy attorney general suggested that laying charges "might jeopardize working relationships between the Province and the RCMP." The commission concluded that the RCMP had improperly accorded special treatment in these investigations and had failed to adhere "to the principle of police independence."[20]

Section 5(1) of the *RCMP Act* provides:

> The Governor in Council may appoint an officer, to be known as the Commissioner of the Royal Canadian Mounted Police, to hold office during pleasure, who, **under the direction of the Minister**, has the control and management of the Force and all matters connected with the Force.

On its face, this section appears to provide the responsible minister with an unlimited power to direct the commissioner of the RCMP. However, the Act has not been interpreted so broadly. In 1999, the Supreme Court of Canada held in R v Campbell

that the responsible minister cannot issue political directions to the commissioner of the RCMP about how the police force pursues a given investigation:

> While for certain purposes the Commissioner of the RCMP reports to the Solicitor General, the Commissioner is not to be considered a servant or agent of the government while engaged in a criminal investigation. The Commissioner is not subject to political direction. Like every other police officer similarly engaged, he is answerable to the law and, no doubt, to his conscience.[21]

In his 2000 article, Dr. Stenning provides numerous examples of controversy about the scope and limits of the RCMP's operational independence and the responsible minister's powers. He concludes that there was at that time "very little clarity or consensus among politicians, senior RCMP officers, jurists (including the Supreme Court of Canada), commissions of inquiry, academics, or other commentators about what exactly 'police independence' comprises or about what its practical implications should be for RCMP-government relations."[22] Since then, controversies have continued to arise and have on occasion led to public inquiries.

As Commissioner Linden observes in the Ipperwash Report, public inquiries should not be the primary way to uncover information about police practices and police / government relations:

> Public accountability and democratic policing cannot depend on this kind of sustained, expensive, and time-consuming effort to get to the bottom of police / government relations issues or controversies … the more important objective should be to promote better police / government relations *before* an incident occurs. Just as importantly, I believe that police / government relations raises important public policy issues, irrespective of whether there is a public controversy.[23]

In an expert report written for the Ipperwash Inquiry, Professor Kent Roach, from the University of Toronto Faculty of Law, describes four potential models of police / government relations. These models range from full police independence, in which "the police are immune and isolated from governmental intervention on a wide variety of matters," to governmental policing, "in which the police are conceived by and large as civil servants subject to Ministerial control and protected only by their ability to refuse to obey unlawful orders and whatever other protections that

civil servants may enjoy." In between these two positions, one model limits police independence to "core functions such as decisions to start criminal investigations and lay charges," while the other, which Professor Roach terms the democratic policing model, "protects police from direction by the government on core law enforcement functions, but maintains the ability of the responsible Minister to be informed about policy-laden elements of criminal investigations and to shape all other policy or public interest matters in policing."[24]

Professor Roach, Dr. Stenning, the McDonald Report, the Ipperwash Report, and the 2017 Quebec *Commission d'enquête sur la protection de la confidentialité des sources journalistiques* all favour the democratic policing model because it best protects the police capacity to pursue investigations while also safeguarding democratic accountability. We share the conclusion reached in these studies and reports that the democratic policing model "creates a flexible, transparent and accountable framework in which police and government can exercise their respective responsibilities, even in a fast paced crisis."[25]

In his report, Commissioner Linden explains that the democratic policing model promotes the exchange of information between a police commissioner and the responsible minister:

> [T]he government has a legitimate authority and often a significant interest in receiving information from the police about ongoing police operations. This authority is justified by the principle of ministerial accountability.
>
> I have also concluded that the government very often has the responsibility to keep the police updated on relevant policy decisions if it can be reasonably foreseen that those decisions will affect police operations or public safety.
>
> The need for full and frank exchange of information between police and government is very much a two-way street. Mutual information exchange promotes better policy *and* operational decision-making.[26]

Commissioner Linden addresses the risk that an exchange of information can become a covert or veiled attempt to improperly direct police operations:

> The best way to minimize the risks of the fact or perception of inappropriate political or governmental interference is to establish institutional and

> procedural protections which ensure that contacts generally occur within established lines of communication and within ministerial lines of authority. The details of any information exchanged between police and government must also be recorded as quickly and accurately as possible.[27]

Commissioner Linden favours the phrase "police operational responsibility" over "police independence," and he pairs that phrase with a principle of "ministerial policy responsibility." He explains that these terms "better represent the complex overlapping spheres of authority and responsibility that characterize the modern world of police / government relations. These terms also emphasize that both the police and the minister have a responsibility to explain and justify their actions to the public."[28]

The Ipperwash Report and the McDonald Report emphasize that ministerial responsibility extends to the "policy of operations." The McDonald Report explains that the policy of operations encompasses "those policies which ought to be applied … in its methods of investigation, its analysis of the results of investigation, and its reporting on those results to government. All policies of operations must receive direction from the ministerial level."[29]

Although this quoted text appears in the context of a discussion of ministerial responsibility with respect to security services, the McDonald Report also emphasizes the ministerial duty to stay informed about and issue directions regarding the criminal law policy of operations: "In our view, the methods, practices and procedures used by the RCMP in executing its criminal law mandate – the 'way in which they are doing it' to borrow the Prime Minister's words – should be of continuing concern to the appropriate Minister."[30]

This ministerial responsibility with respect to the policy of operations was also affirmed by Commissioner Dennis O'Connor in his 2006 *Report of the Events Relating to Maher Arar: Commission of Inquiry into the Actions of Canadian Officials in Relation to Maher Arar*. This inquiry focused on the rendition and torture of Canadian citizen Mr. Arar, including the role of the RCMP with respect to him.

Commissioner Linden concludes in the Ipperwash Report that directives such as those discussed in the Arar Report reflect key principles of democratic accountability:

> [A written ministerial] directive establishes the government's general expectations for how the RCMP will perform its duties in certain sectors

or situations. In so doing, the federal government has transparently and prospectively stated its policy and operational objectives in these fields. Because the directives are transparent, accountability is enhanced. Because they are prospective, the possibility of controversy or inappropriate activities is reduced.

The RCMP has publicly acknowledged that these directives are helpful in establishing a policy framework for areas of RCMP activities requiring clarification by the political executive. The RCMP has also stated that the directives provide it with standards, in selected areas of policing activity, for achieving a balance between individual rights and effective policing practice. The RCMP has further stated that the directives are valuable because they inform the public about the character of the supervision of the RCMP provided by the federal executive.[31]

Ministerial Directives

While the principles of democratic policing set out in the McDonald Report and the Ipperwash Report are broadly consistent with the existing *RCMP Act* and case law, we believe that statutory amendment and the adoption of written policy are necessary to ensure that these principles become firmly entrenched and widely understood. The controversy that arose in our proceeding over the proper relationship between Commr. Lucki, on one hand, and the federal minister of public safety and emergency preparedness (as the portfolio was then titled) and the prime minister, on the other, illustrates that misunderstandings about police operational responsibility and ministerial policy responsibility persist within the RCMP and in broader public conversation in Canada. In a matter as fundamental to democracy as police / government relations, the police, the government, and the public are not well served when they depend on convention alone.

LESSON LEARNED

The minister responsible for the RCMP serves an important democratic accountability function. The minister can and should issue written directions to the RCMP about policy matters, including the policy of operations. It is also necessary for the minister and the commissioner to exchange information, including information about specific investigations or police operations, to allow the minister to discharge their democratic role. However, the minister must not direct the RCMP about how it pursues particular investigations. Both the minister and the RCMP should be publicly accountable for the ways in which they discharge their responsibilities.

Recommendation P.38

MINISTERIAL DIRECTIONS TO THE RCMP COMMISSIONER

The Commission recommends that

(a) Federal Parliament should amend section 5(1) of the *RCMP Act* to provide:

> The Governor in Council may appoint an officer, to be known as the Commissioner of the Royal Canadian Mounted Police, to hold office during pleasure, who, **subject to this Act and any written directions of the Minister, is responsible for** the control and administration of the Force.

(b) The *RCMP Act* be further amended to include the following provisions:

> (a) The Minister must cause a copy of any such written direction given to the Commissioner to be:
>
> > (i) published in the *Canada Gazette* within eight days of the date of the direction; and
> >
> > (ii) laid before the Senate and the House of Commons within six sitting days of the direction if Parliament is then in session, or, if not, within six sitting days after the commencement of the next session of Parliament.

> (b) No Ministerial direction may be given to the Commissioner in relation to the appointment, transfer, remuneration, discipline, or termination of a particular person.

These provisions are modelled on those in the South Australian *Police Act* (1998), which Commissioner Linden identifies as representing best practice. He also observes that these provisions have Canadian analogies with respect to the relationship between the Nova Scotia director of public prosecutions and the responsible minister (implemented in response to a recommendation of the Marshall Inquiry)[32] and the equivalent federal model. As noted, in the Arar Report, Commissioner O'Connor also recommends the use of ministerial directives with respect to the national security activities of the RCMP.

Commissioner Linden sets out the value of providing for written and public ministerial directives for clarifying the respective roles and responsibilities of the police and the responsible minister, and for safeguarding against other ministers or political staffers seeking to direct a police commissioner:

> A statutory requirement that both general guidelines and specific directives be reduced to writing and made public should help to ensure that the responsible minister is held accountable for any political intervention in policing. It should also assist in ensuring that government intervention flows through the responsible minister. This, in turn, should discourage central agencies or political staff from performing an end run around the traditional and statutory framework of ministerial accountability for policing.
>
> Government-wide consultation is perfectly acceptable, and indeed often desirable. The benefit of ministerial directives, however, is that they ensure that government policy is properly filtered and conveyed through the appropriate minister. This should help ensure that directions given to the police respect the core of police independence and the expertise of the police in operational and law enforcement matters.[33]

We would add that adhering to a practice of issuing written directives also helps to protect government and the commissioner of the RCMP against allegations of underhandedness or of covertly seeking to exercise political influence over police operational responsibilities. As Dr. Stenning documents, such allegations

have often been made in Canada and in other jurisdictions including Australia and England. Requiring that ministerial directions be in writing, published in the *Canada Gazette*, and laid before Parliament allows them to be understood and debated. These amendments would give a commissioner who is concerned about advice offered by the responsible minister (or any other member of government or political staff) the ability to ask that directions be reduced to writing in accordance with the statutory requirement. Most important, however, requiring that ministerial directives be in writing and published will ensure that the public is aware of how the police are being directed.

Recommendation P.39

POLICIES GOVERNING THE ROLES AND RESPONSIBILITIES OF THE RCMP AND MINISTER OF PUBLIC SAFETY

The Commission recommends that

(a) The RCMP and the minister of public safety should adopt complementary written policies that set out their respective roles, responsibilities, and mutual expectations in police / government relations. These policies should adopt the principles and findings on police / government relations outlined in Chapter 10 of Volume 5, Policing, of this Report, including specific provisions on the following issues:

  (i) police operational responsibilities;

  (ii) government policy responsibilities;

  (iii) policy of operations; and

  (iv) information exchanges between the RCMP and the government.

(b) These policies should be posted on the RCMP and the Public Safety Canada websites.

Recommendation P.40

PROTECTING POLICE OPERATIONS

The Commission recommends that

The RCMP should establish policies and procedures to protect incident commanders, investigators, and front-line members from exposure to direct government intervention or advice.

Adopting a clear, public policy to govern the exchange of information between the RCMP and the government will support the principles of police operational responsibility and ministerial responsibility and mitigate the risk of inappropriate interference with front-line operational personnel. The value of such a policy is illustrated by two incidents documented by Commissioner Linden in which a local member of the Ontario Legislative Assembly and a mayor engaged directly in interactions with Ontario Provincial Police officers about how the OPP was managing the protest in Ipperwash Provincial Park. A written policy on information exchange will protect operational members from direct approaches by politicians or political staffers and will clarify that information exchange is a matter for the commissioner of the RCMP and the responsible minister. To protect this principle, the office of the responsible minister may, on occasion, be obliged to facilitate requests for information by other members of parliament. Such requests should be facilitated, provided that they do not encroach on the principle of police operational responsibility.

The Management Advisory Board

In 2007, the Brown Task Force proposed that a board of management be established for the RCMP. Mr. Brown and his colleagues suggested that this board be given the following functions:

> [O]versight (stewardship) of the organization and administration of the RCMP and the oversight of the management of its resources, services, property, personnel and contracts. Its responsibilities would include:

- human resource management, policies and practices
- resource allocation
- budgeting and financial management
- strategic planning and oversight of implementation
- risk identification and management
- succession planning
- internal and public communications
- establishment of objectives for senior management and performance measures for those objectives[34]

The Brown Task Force envisaged that this board of management would be "accountable for the matters within its responsibility to the Minister and through him or her, to Parliament."[35] The Brown Task Force also recommended that the board's performance periodically be reviewed by the Auditor General of Canada.

In 2010, the final report of the RCMP Reform Implementation Council confirmed that it was "convinced that ongoing reform of the RCMP requires a new approach to governance and management of the Force, one that opens the way to outside advice and provides an external challenge to executive decision-making."[36] It concluded that "a formally established board of management for the RCMP, as recommended by the Task Force in 2007, is an essential and urgent requirement of ongoing RCMP reform."[37] Nonetheless, this recommendation was not implemented.

In March 2017, Sheila Fraser, the former auditor general of Canada, was asked to review four cases brought against the RCMP by former employees who sought damages for workplace sexual harassment. Ms. Fraser recommended, among other things, that the Government of Canada establish a Management Advisory Board for the RCMP. Two years later, in June 2019, the board was established "to provide expert external advice and guidance to the RCMP Commissioner on key modernization and management matters."[38] The *RCMP Act* was amended in December 2019 to give the Management Advisory Board a formal statutory role and powers, including the capacity to obtain information from the RCMP. The deputy minister of public safety and emergency preparedness and the commissioner, or their delegates, receive notice of the board's meetings, and they may attend and take part in, but not vote at, those meetings. Members of the board are appointed by the Governor in Council on the recommendation of the federal minister of public safety.

The Management Advisory Board serves some of the functions proposed by the Brown Task Force and the Reform Implementation Council. In her interview, Commr. Lucki alluded to several initiatives being undertaken by the board. In her testimony, she explained that she has taken "all" the advice given by the board, including with respect to harassment resolution, recruitment, and the basic training offered at the RCMP Academy, or Depot facility, in Regina.

Section 45.18(3) of the *RCMP Act* states that "[t]he Management Advisory Board may provide the Minister with a copy or a summary of any advice, information or report that it provides to the Commissioner."[39] When Public Safety Canada first announced the implementation of the board, its backgrounder also noted that "[p]ursuant to subsection 5(1) of the *Royal Canadian Mounted Police Act* (RCMP Act), the Minister may direct the Commissioner to seek the Board's advice and require that the Commissioner report back, including on actions taken based on that advice."[40]

We heard from RCMP witnesses that the Management Advisory Board is performing an important role in Commr. Lucki's efforts to modernize the RCMP. Journalists and academics have sought to learn more about the advice given by the Management Advisory Board and directives issued by the responsible minister, but their efforts have not succeeded. In December 2020, board chair Richard Dicerni told the *Toronto Star* that the board mostly provides advice in verbal form, and he referred other questions about the board's advice to the RCMP. An RCMP spokesperson declined to make the board's advice public, explaining that Commr. Lucki "is also consulting other committees and expert resources to help shape and refine our plans, so it is an iterative process drawing on many resources. For that reason, we've elected to focus our internal and external updates on decisions made, rather than the specific advice provided."

A central principle of the Brown Task Force recommendation was that the work of a board of management should adhere to the principles of transparency and democratic accountability that otherwise apply to the police. The Brown Task Force recommended that the board they envisaged should report to the responsible minister and, through them, to Parliament on matters within their responsibility. We agree with this recommendation and consider that it would strengthen the oversight and advisory role of the Management Advisory Board.

LESSON LEARNED

The work of the Management Advisory Board for the RCMP should adhere to the principles of transparency and democratic accountability that otherwise apply to the police.

Recommendation P.41

ADVICE OF THE MANAGEMENT ADVISORY BOARD

The Commission recommends that

(a) Federal Parliament should amend Section 45.18(3) of the *RCMP Act* to provide that:

> The Management Advisory Board must provide the Minister with a copy or a summary of any advice, information, or report that it provides to the Commissioner, within eight days of providing that advice.

(b) Federal Parliament should add a new subsection, 45.18(4), to the *RCMP Act* to provide that:

> The Minister must cause a copy of any document provided by the Management Advisory Board pursuant to section 45.18(3) to be:
>
> (a) published on the website of Public Safety Canada; and
>
> (b) laid before the Senate and the House of Commons within six sitting days of the direction if Parliament is then in session, or, if not, within six sitting days after the commencement of the next session of Parliament.

Part V of the *RCMP Act* attends to the principle of police operational responsibility on certain specific grounds, including by preventing the Management Advisory Board from having access to information if such access might compromise or hinder the investigation or prosecution of any offence. Given the presence of this

protection within the *RCMP Act*, we consider it is not necessary to establish an exception to the principle that advice given by the Management Advisory Board to the RCMP commissioner should, as a matter of course, be published.

Civilian Review and Complaints Commission

The Civilian Review and Complaints Commission for the RCMP (CRCC) is an independent agency that serves an important accountability function. It has responsibility for ensuring that public complaints made about the conduct of RCMP members are examined fairly and impartially. It also has the power to initiate reviews of RCMP conduct, including the power to conduct systemic investigations. Such investigations can be initiated by the CRCC or at the request of either the minister of public safety or a provincial minister responsible for policing in a province where the RCMP provides policing services. Independent civilian review is an essential aspect of maintaining public confidence in policing services.

The RCMP has historically been very slow to respond to public complaints and to the CRCC. In December 2021, the Federal Court described the CRCC process as follows:

> A complaint against the RCMP or one of its members is investigated by the RCMP's internal board of inquiry, created under Part I of the RCMP Act, unless the CRCC decides to investigate it itself. Even when the RCMP investigates the complaint internally, an unsatisfied complainant can refer it to the CRCC for review.
>
> In both cases, section 45.76 of the RCMP Act provides that on completion of [an] investigation or hearing, the CRCC prepares and sends to the Minister and the RCMP Commissioner, an interim report setting out any findings and recommendations with respect to the complaint that it sees fit. Of note, the complainant does not receive a copy of the interim report. "As soon as feasible" after receiving the interim report, the RCMP Commissioner must provide her response and indicate any actions that have been taken or will be taken with respect to the complaint or, alternatively, explain why none will be taken. After considering the Commissioner's response, the CRCC prepares a final report with findings and recommendations that is, this time, also sent to the complainant.[41]

The Federal Court noted that, for over a decade, the CRCC and its predecessor had raised concerns about delays in the RCMP commissioner's response to interim reports. The passage in 2014 of an amendment to the *RCMP Act* requiring the commissioner to provide a response "as soon as feasible" and the settling of a memorandum of understanding in 2019 setting a six-month target for the RCMP commissioner's response had failed to address the problem.

This case was brought by the BC Civil Liberties Association against the RCMP commissioner with respect to a complaint filed by the association in 2014. The complaint alleged that RCMP members had illegally spied on Indigenous and climate advocates who were opposed to the proposed Northern Gateway pipeline and that the RCMP had unlawfully shared information with other government bodies and private sector actors. The RCMP commissioner had received the CRCC's interim report in June 2017, but had not provided her response by November 2020, when the BC Civil Liberties Association filed its application against the commissioner. The commissioner issued her written response shortly after the application was filed. The BC Civil Liberties Association pressed its application for a declaration. As the Federal Court noted, this response was issued "more than three years after receiving the Interim Report and almost seven years after the Applicant filed its complaint with the CRCC."[42] An RCMP witness confirmed that no analyst was assigned to work on this report until July 2020.

In its decision, the Federal Court emphasized that the CCRC performed a crucial oversight role:

> [I]t is in the public interest to have a police oversight institution that functions properly and is unobstructed. The CRCC considered that the complaint it received from the Applicant merited a public interest investigation. The Applicants have explained the important consequences of these delays on the public's ability to obtain information about police misconduct and to remedy policies that can cause harm to the public.[43]

The court also described the RCMP's responsibility with respect to providing a written response "as soon as feasible":

> [A] three-and–a-half year delay is certainly not a reasonable interpretation of the "as soon as feasible" in the Act. Nor does it mean whenever resources become available. In the case before me, it took the Commissioner a full three years to assign an officer to the case and once the

> officers were assigned, it took the Commissioner only a few months to issue a five-page response to the Interim Report, in which she accepts all the CRCC's findings and recommendations. I agree with the Intervener that it would be imprudent to allow the Commissioner to under-resource the Directorate and claim that lengthy delays are due to volume of Interim Reports and insufficient resources. Rather, "as soon as feasible" requires an institution to arrange its resources such that it can discharge its obligations "quickly and efficiently."[44]

The court concluded that the RCMP commissioner breached her statutory duty to provide a written response "as soon as feasible."[45]

In July 2020, Portapique resident Leon Joudrey made a complaint to the CRCC about the RCMP's response to the mass casualty, and in particular about how he was treated by members of the RCMP H Division Emergency Response Team. In his letter, Mr. Joudrey said that RCMP members had pointed a firearm at him and failed to maintain firearm safety in the proximity of one of his dogs; that RCMP members had failed to warn him of the threat to his safety or to evacuate him from Portapique; and that he had been able to drive freely through crime scenes in Portapique in the absence of RCMP scene security.

In accordance with the *RCMP Act*, this complaint was initially referred to Commr. Lucki for internal investigation. In her letter transmitting Mr. Joudrey's complaint, the chairperson of the CRCC, Michelaine Lahaie, recommended "that the public complaint investigator assigned be from outside 'H' Division." Contrary to her recommendation, on July 31, 2020, the investigation of Mr. Joudrey's complaint was assigned to Insp. Donald (Don) Moser, a supervisor of the H Division Emergency Response Team. It appears that a second investigator, Sgt. Derrick Blanche, from H Division, was also assigned to this file. Neither Insp. Moser nor Sgt. Blanche is a member of the RCMP Professional Responsibility Unit. In an interview with the Commission, Insp. Moser explained that because the Professional Responsibility Unit has a limited capacity, public complaints are often addressed by assigning a "capable investigator."[46] He was uncertain whether RCMP policy sets out any timeline for such investigations.

LESSON LEARNED

Conducting investigations into public complaints against police officers is a specialized skill. Police agencies should ensure that such investigations are conducted by personnel who are properly trained in conducting such investigations and who do not have a real or perceived conflict of interest.

Recommendation P.42

INTERNAL INVESTIGATION OF PUBLIC COMPLAINTS

The Commission recommends that

(a) The RCMP allocate sufficient resources to the RCMP Professional Responsibility Unit to ensure that it has the capacity to conduct investigations into public complaints.

(b) The RCMP should not assign public complaints to the direct supervisor of a member who is the subject of a public complaint or to investigators within the same program as a subject member.

In May 2022, Mr. Joudrey advised us that he had received no resolution for his complaint: "I just keep getting letters in the mail every month that they'll, they got no news … So, I just get form letters every month."[47]

On October 4, 2022, counsel for the RCMP advised the Mass Casualty Commission:

> As of 2022-08-22, the Leon Joudrey public complaint is still under investigation. Although much effort has been applied by the assigned investigator to navigate the complex nature of this situation, there still remains aspects which require a full examination. Currently, the assigned investigator is awaiting a response from two RCMP critical incident commanders, whom were subsequently identified as subject officers, to advise if they wish to provide the investigator a statement. Both are now retired. It is a likelihood that the investigator will have to obtain their interviews

> and testimony from the MCC, review those materials in detail, to properly inform the investigation.
>
> The investigator in this matter is balancing substantive duties within a high risk investigative team, important leave commitments, and awaiting responses of some subject officers. Although the investigator has been provided administrative support where needed, there is no accurate timeline to completion available at this time.[48]

Sadly, Mr. Joudrey died in late October 2022. He never received any resolution to his complaint against the RCMP. At the time of his death, more than two years had passed since he first filed his complaint.

The *RCMP Act* does not set timelines for the RCMP's initial investigation of public complaints. Section 45.56 of the *RCMP Act* provides: "As soon as feasible after being notified of a complaint, the Commissioner shall consider whether the complaint can be resolved informally and, with the consent of the complainant and the member or other person whose conduct is the subject matter of the complaint, may attempt to resolve it informally." It appears that no attempt at informal resolution was made in Mr. Joudrey's case. Section 45.64 provides:

> As soon as feasible after the investigation of a complaint is completed, the Commissioner shall prepare and send to the complainant, the member or other person whose conduct is the subject matter of the complaint and the Commission a report setting out
>
> (a) a summary of the complaint;
>
> (b) the findings of the investigation;
>
> (c) a summary of any action that has been or will be taken with respect to the disposition of the complaint; and
>
> (d) the complainant's right to refer the complaint to the Commission for review, within 60 days after receiving the report, if the complainant is not satisfied with the disposition of the complaint.

The failure to stipulate a time period for the initial investigation of public complaints is a significant gap in the *RCMP Act*. Failure to investigate promptly can have adverse effects, including the fading of witness memories and the potential for automatic destruction of records pursuant the RCMP's two-year document retention policy. Delay also undermines trust in the effectiveness of the public

complaints process. The reasons offered by the RCMP for the delay in Mr. Joudrey's case suggest that the RCMP has not arranged its resources so that it can respond to public complaints in a timely manner. As the Federal Court observed, the public complaints process should not be delayed until "whenever resources become available."[49]

In February 2022, Ms. Lahaie issued a statement confirming that by late 2021, the "RCMP cleared their backlog of responses to CRCC interim reports and since April 1st, 2021, all new CRCC interim reports have been responded to within the agreed upon six-month time frame."[50] A statement posted on the RCMP website dated December 9, 2022, confirms this information. In addition, the RCMP posted an overview of its commitments on responses to CRCC recommendations. These developments are encouraging and a welcome improvement the RCMP's transparency. However, as Ms. Lahaie suggests in her statement, statutory amendments to the *RCMP Act* are necessary to include timelines for RCMP responses to CRCC recommendations and to require the RCMP to report publicly every year on its implementation of CRCC recommendations. We add that timelines should be stipulated for the RCMP's initial investigation of a public complaint. In the ordinary course, this timeline should be no more than three months.

Recommendation P.43

CIVILIAN REVIEW AND COMPLAINTS COMMISSION PROCESS

The Commission recommends that

(a) Federal Parliament amend the *RCMP Act* to specify:

  (i) timelines for the RCMP commissioner to conduct an initial investigation and attempt to resolve public complaints, and to respond to CRCC interim reports; and

  (ii) a requirement for the RCMP to publicly report annually on the implementation of CRCC recommendations.

(b) The federal minister for public safety issue a written direction to the commissioner of the RCMP to prioritize the timely investigation of public complaints at the initial stage of the CRCC process and to work to resolve these complaints where possible at the initial stage.

As noted, the CRCC also has the capacity to conduct systemic investigations on its own initiative or on the request of a responsible minister. Since 2014, the CRCC has conducted systemic investigations on a number of topics including street checks, strip searches, and systemic discrimination. It has also exercised its systemic power to study RCMP policing in northern British Columbia, where it found that "largely, the Indigenous population did not use the public complaints system, and it was because there was a lack of trust in it."[51] In 2022, the CRCC initiated a systemic review of the complaints process in Nunavut:

> [A]t the Commission, our sense was that the Territory of Nunavut is underrepresented in the public complaint process. We do not get a lot of complaints from the territory but we realize that it is a population that is, some would say, overpoliced. And so we wanted to look at that to understand why the process isn't being used and bring forward recommendations and findings to hopefully affect change to that.[52]

Ms. Lahaie observed that systemic investigations offer a means by which community members "can share what their experiences are with policing, but without having the jeopardy of having to file a public complaint."[53]

The chairperson also has the power to initiate a public interest investigation into a specific matter "when the belief is that it's not in the public interest for the RCMP to conduct the investigation of the complaint."[54] The CRCC used this power to investigate the RCMP's investigation into the death of Colten Boushie and the events that followed his death. Mr. Boushie, a Cree man, was shot and killed by Gerald Stanley in a rural area of Saskatchewan in 2016. The CRCC's report on the RCMP's handling of Mr. Boushie's death made findings on several topics that arise within the mandate of this Commission, including next of kin notification and the RCMP's management of crime scenes. The CRCC found that the RCMP's conduct toward Mr. Boushie's mother, Debbie Baptiste, "was discriminatory on the basis of her race, or national or ethnic origin."[55] Ms. Baptiste is also Cree.

In its final report on the Boushie investigation, the CRCC observed:

> Surprisingly, despite generally accepting almost all findings and recommendations, the RCMP's response said very little about the issues at the heart of this case, while devoting much attention to more minor and technical points about the few findings the RCMP disagreed with. These points often related to resources and logistical issues that were discussed

> at length, while the more important issues were often addressed with few words. In that sense, the response could be viewed as a missed opportunity for the RCMP to take responsibility for the manner in which Mr. Boushie's family and friends were treated.[56]

These observations resonate with those we offer elsewhere in this Report about RCMP management's longstanding aversion to taking responsibility for errors and its lack of attention to rebuilding community trust after errors have been made.

In July 2022, the CRCC issued a public statement advising that it had commenced a public interest investigation into the RCMP's handling of Susan (Susie) Butlin's complaint of sexual assault and her subsequent murder. Ms. Butlin, a resident of Bayhead, NS (Colchester County), was killed in 2017 by her neighbour Ernie Duggan. Before her death, she made numerous calls to the RCMP, initially to lay a complaint of sexual assault, and subsequently to make further complaints about his increasingly threatening behaviour toward her. We discuss the Duggan case and the RCMP's response to Ms. Butlin in more detail in Part D of this volume.

Representatives of the CRCC participated in a Commission roundtable at which accountability and oversight mechanisms were discussed. Ms. Lahaie explained that the CRCC's capacity to conduct investigations depends on budget and, when commencing a systemic investigation or a public interest investigation, she must send a letter to the minister of public safety indicating that she has sufficient resources to conduct that investigation. Professor Roach observed at the same roundtable that "when budgets get strained, the first thing that goes are the systemic reviews."[57] Ms. Lahaie confirmed that it is possible for police misconduct to go unaccounted for because there is not adequate money in the CRCC budget.

The CRCC is doing crucial work to investigate and hold the RCMP publicly accountable for misconduct and to recommend changes that will improve the quality of RCMP policing and community relations. It is attentive to systemic and structural issues, and it is working actively to improve community trust in its process. In addition, it is striving to understand how to be more accessible to members of marginalized communities, who are less likely to lodge police complaints. These efforts include working with Indigenous communities to adopt Indigenous legal approaches to complaint resolution. As a permanent independent civilian agency, the CRCC has the capacity to be responsive to community concerns as they emerge, and it is more cost-effective than a public inquiry. It has recently taken further steps to improve its own transparency and

accountability – for example, by publishing summaries of reviewed public complaints on its website. Its cost in 2020/21 was approximately $11.5 million. The RCMP's gross spending in 2021/22 was approximately $5.2 billion.

LESSON LEARNED

Agencies that investigate public complaints against police agencies must be adequately funded to perform their work fully and effectively. Failure to provide adequate funding risks impairing the independence of these agencies.

Recommendation P.44

CIVILIAN REVIEW AND COMPLAINTS COMMISSION FUNDING AND POWERS

The Commission recommends that

(a) The Government of Canada should ensure that the Civilian Review and Complaints Commission has sufficient stable funding to fulfill its mandate. In particular, in addition to reviewing public complaints, it must be able to conduct systemic investigations and public interest investigations as it deems necessary, and to explore alternative complaint resolution mechanisms, such as Indigenous legal approaches to dispute resolution.

(b) The minister for public safety should issue a written direction to the RCMP commissioner that RCMP employees should support efforts by the Civilian Review and Complaints Commission to explore alternative complaint resolution mechanisms.

Relations with Contract Partners

The RCMP is a national police service that provides a mix of federal and contract policing services across Canada from coast to coast to coast. A recurring theme of recent reviews of contract policing has been the challenge of ensuring that the RCMP's provision of contract policing services is responsive to the distinctive needs of the communities in which those services are provided. As identified by expert report writers Dr. Christopher (Chris) Murphy, professor of sociology (ret.) at Dalhousie University and University of King's College, and Cal Corley, chief executive officer of the Community Safety Knowledge Alliance, former assistant commissioner of the RCMP and former director of the Canadian Police College, the lack of responsiveness to community has been a longstanding theme of criticisms of the RCMP's contract policing and this feature may in fact be inherent to the historical purpose of the RCMP.[58] In this section, we consider how the RCMP's approach to contract policing contributes to the challenges of providing responsive policing services to the range of communities that the RCMP serves. Here, we review Dr. Murphy and Mr. Corley's analysis and consider some recent innovations that seek to improve RCMP / community relations within the existing contract policing model. In a 1991 academic article, Dr. Murphy explained:

> RCMP detachment policing is in many ways the antithesis of the traditional small-town municipal police model. It's an historical remnant of the colonial policing model in which the primary purpose of law enforcement was to ensure that national standards of legal order prevailed where necessary over local custom and circumstance. Philosophically, detachment police were and still are intended to stand apart from or be "detached" from being swayed by local community politics or public opinion, in order to facilitate the impartial exercise of law and order, i.e., "without fear or favour." As detached units of a large, centralized police bureaucracy, local RCMP detachments are fiscally and politically independent of the local community and respond primarily to the centrally derived policies, enforcement priorities, and production pressures of the organization and not necessarily the local community.[59]

In their expert report for the Commission, Dr. Murphy and Mr. Corley identify a number of aspects of the RCMP's "organizational, institutional and cultural characteristics"[60] that limit its capacity to respond to local community needs and context.

These features include the centralized nature of the RCMP, which constrains its adaptability and responsiveness including, for example, by being slow to add additional resources even when funding for those resources is approved by the province or the municipality; by giving communities little say over personnel and staffing, as transfers and promotions are determined by internal policies and priorities; and by the operation of RCMP policies and federal legislation that limit information sharing and collaboration with local agencies and communities.

Community Voice

The Brown Task Force similarly noted the lack of community voice in key staffing decisions and recommended that "provincial / local officials should have significant input into the selection of the RCMP members who fill key roles at the division, district and detachment levels."[61] The current Provincial Policing Service Agreement and Municipal Policing Service Agreement provide for the provincial minister or the municipal chief administrative officer to request consultation before the appointment of a detachment commander, and also to ask the RCMP to consult with the community served by that detachment. Dr. Murphy and Mr. Corley note that these provisions are presently rarely used, which "greatly limits the ability of communities to ensure that [the] local detachment model of policing and its policing priorities are in accordance with community needs and expectations."

A 2011 report on the delivery of policing services in the Yukon, prepared by a joint committee co-chaired by the deputy minister of justice, the commanding officer of the Yukon RCMP, and the justice manager of the Council of Yukon First Nations, also considered the importance of a community voice in staffing decisions. *Sharing Common Ground: Review of Yukon's Police Force* recommended that First Nations and municipal leaders be "offered the opportunity to participate in the selection of detachment commanders" and be "informed and consulted when members are transferred in and out of a community." The report "stressed the importance of building strong relationships between the police and community members. This is fundamental to the delivery of high-quality policing services. In order to build strong relationships, the members of the community must know who the police officers are in their community, and the members must come to know their community where they serve."[62]

Sharing Common Ground recommended that community leaders develop an orientation process to introduce RCMP members to the community. It specifically recommended that this orientation "should include understanding of the community's history, First Nation culture and language, and social context."[63] We commend this approach to other communities that are policed by the RCMP.

LESSON LEARNED

Provincial and municipal officials have authority to ensure greater community involvement in RCMP decisions about staffing.

Recommendation P.45

COMMUNITY INVOLVEMENT IN SENIOR RECRUITMENT

The Commission recommends that

(a) Provincial ministers and municipal chief administrative officers should discharge their responsibility under the Provincial Police Services Agreement and the Municipal Police Services Agreement to ensure that they and the community are consulted on the selection of detachment commanders.

(b) The RCMP should facilitate this consultation by ensuring that the provincial minister or the municipal chief officer (as applicable) receives timely notice of a pending change in detachment commander.

Devolving Decision-Making to Local Settings

The Brown Task Force made the following recommendations with respect to relations between RCMP national headquarters and its contract divisions:

> **Recommendation 41 – Delegation of Decision Making with Respect to Contract Policing** The RCMP should examine and review its approval authorities to ensure that those closest to operational police activity have the requisite authority to make decisions in a timely manner.
>
> **Recommendation 42 – Contract Partner Participation** Headquarters should give greater weight to the views and priorities of contracting authorities and should involve them in a more meaningful way in decisions that have an impact on their jurisdictions.
>
> **Recommendation 44 – Roles and Responsibilities of Headquarters** The RCMP should develop a written mandate defining the roles and responsibilities of Headquarters and its relationship with its divisions.[64]

We endorse these helpful recommendations. Unfortunately, a number of the incidents reviewed in this volume demonstrate that the RCMP has not implemented these recommendations. In an interview with the Commission, C/Supt. Darren Campbell observed, "We have a lot of layers of approval in terms of getting the things that we need."[65] For example, as the evidence we set out in Part A and Part B of this volume shows, the principle that "those closest to operational police activity have the requisite authority to make decisions" is not followed with respect to the process of calling out the specialist resources that respond to a critical incident (this call-out requires approval by a support services officer, rather than being a matter over which the risk manager or the critical incident commander has authority) or sending public communications during a critical incident (the standard operating procedures for which contemplate the involvement of the criminal operations officer, at least in the initial stages). The RCMP's complex process can result in years of delay before apparently straightforward recommendations are implemented.

LESSON LEARNED

Past inquiries and reviews have documented problems in the structure of RCMP contract policing, particularly regarding clarity in the respective roles and responsibilities of contract partners, national RCMP headquarters and RCMP contract divisions. Past recommendations have not been fully implemented, and problems identified in past processes persist today.

Recommendation P.46

IMPLEMENTING THE 2007 BROWN TASK FORCE RECOMMENDATIONS

The Commission recommends that

The RCMP implement the following recommendations that were made by the Brown Task Force in 2007:

> **Recommendation 41 – Delegation of Decision Making with Respect to Contract Policing** The RCMP should examine and review its approval authorities to ensure that those closest to operational police activity have the requisite authority to make decisions in a timely manner.
>
> **Recommendation 42 – Contract Partner Participation** Headquarters should give greater weight to the views and priorities of contracting authorities and should involve them in a more meaningful way in decisions that have an impact on their jurisdictions.
>
> **Recommendation 44 – Roles and Responsibilities of Headquarters** The RCMP should develop a written mandate defining the roles and responsibilities of headquarters and its relationship with its divisions.

Similarly, while there has been some progress with respect to involving contract partners in decisions that have an impact on their jurisdictions, this progress is limited. We obtained some records from meetings of the RCMP's Contract Management Committee, and other documents relating to the relationship between the RCMP and contracting partners. The Contract Management Committee consists of representatives from Public Safety Canada, the RCMP, and contracting provinces and territories. There is no equivalent body for municipalities who enter contracts for police services via Municipal Police Services agreements.

Contract Management Committee documents show that in 2017, at the time of a five-year review of the current Provincial Police Services Agreement:

> [T]he timing, processes and level of consultation and engagement on issues related to the governance, cost, quality or capacity of the service or RCMP program has not met the expectations of the Parties. [Provinces and territories] have raised issues with some items being presented after

> a final decision has already been made, and have expressed concerns regarding misunderstandings of issues associated with consultation (when must this occur, for what issues and what timelines) and the process and level of consultation necessary for various items … The contract jurisdictions are of the view that many decisions have been made unilaterally with little or no consultation through the Contract Management Committee.[66]

An October 2020 record of decision by the Contract Management Committee similarly records that representatives of provinces and territories "raised significant concerns with the methodologies used" by the RCMP to calculate demand for regular members in contract jurisdictions, "noting that the figures shown … are not representative of what's actually on the ground." The provincial and territorial representatives stated that a report produced by the RCMP on vacancies in member positions "is problematic because it cannot be used for its intended purpose – decision making." They were also dissatisfied because a working group struck to work on this issue was not meeting and they were not consulted in developing definitions and procedures that drive the RCMP's analysis of demand for members. The RCMP response to these concerns, as noted in this record, is revealing with respect to its approach: "The RCMP appreciated the feedback and level of engagement from [provinces and territories] and looks forward to future collaboration efforts."[67] All parties agreed to re-engage the working group to continue the discussion.

In the same meeting, provinces and territories expressed concern over the level of consultation in which the RCMP had engaged with respect to its strategic plan: "[T]hey do not feel that the RCMP has held meaningful consultations on the Plan, but rather that they are being advised on what actions the RCMP is taking under the plan."[68] In response, the RCMP committed to providing "a more comprehensive draft" for provincial and territorial comment.

In *Broken Dreams, Broken Lives*, his 2020 report on the claims process that arose from the RCMP's settlement of a class action by women who had experienced sexual harassment and gender-based or sexual orientation–based discrimination while working for the RCMP, the Honourable Michel Bastarache noted how slowly the RCMP moves in response to issues arising at the Contract Management Committee. He specifically described the impact of the RCMP's failure to resolve issues such as how to account for "soft vacancies," which include parental leave, on workplace culture:

> In 2015, the [RCMP] senior management committee decided that eacH Division would manage their own vacancies related to parental leave.
>
> When asked, the RCMP told my Office that "… there is work that has started which is looking at enhancing its approach to vacancy management by considering the incorporation of "soft" vacancies (i.e., maternity / paternity leave, off-duty sick) into its resource planning models. This model will allow the RCMP to have sustainable processes in place that proactively anticipates future resource requirements." However, at the time of writing, nothing had yet been put in place. The RCMP states that it is "… still at the preliminary stages of working on this model, but anticipate that it will be completed within the next 2–3 years."
>
> …
>
> The RCMP has been aware of the problem of understaffed detachments for years and in any event since 2007. It agreed to take action on the issue in 2015. It is now 2020 and very little progress appears to have been made on this issue leaving detachments short of human resources and women bearing the displeasure and resentment of their colleagues when they announce their pregnancies. Women still report being given humiliating duties, inconsistent with their training and abilities when they are placed on administrative duties as a result of pregnancy.[69]

The failure to address the soft vacancies issue also has an adverse impact on the operational effectiveness of RCMP detachments. On the evening of April 18, 2020, four RCMP members were working on general duty policing from the Bible Hill detachment, one of whom was an acting corporal, despite the fact that the member allocation for Bible Hill contemplated the availability of six members. We documented in Part A of this volume that many of those involved in the RCMP's critical incident response to the mass casualty were in acting roles, including several of the senior non-commissioned officers who were responsible for coordinating the response of general duty members. We also noted C/Supt. Christopher (Chris) Leather's suggestion that the RCMP does not adequately provide for a transition process when one officer leaves a given position and another begins. The Contract Management Committee records suggest that the RCMP's failure to address these challenges is a topic of discussion at that table, and that these concerns have not been resolved despite the emphasis placed on this issue by provinces and territories.

Mr. Bastarache concluded in his report: "The RCMP must ensure that it has a system to ensure that resource levels required for operational duties are always maintained and, on an organization-wide basis, not on a Division by Division basis over the next 2–3 years." He also suggested: "The idea of floaters – members that can be deployed where necessary to ensure appropriate coverage, should be endorsed."[70] We endorse these recommendations.

LESSON LEARNED

Longstanding issues with soft vacancies and challenges with recruitment mean that contracting provinces and territories do not receive the active service of the number of RCMP members for which they have contracted.

Recommendation P.47

ADDRESSING CONCERNS ABOUT POSITION VACANCIES

The Commission recommends that

The RCMP should adopt a system that ensures that contracting provinces and territories receive the active service of the number of members for which they have contracted. The RCMP should ensure that temporary vacancies are filled to ensure that appropriate coverage is provided in contract jurisdictions.

Field supervision is not always available to general duty members in rural areas when required. We discuss the impact of this shortcoming in the RCMP's contract policing structure in Volume 2, What Happened, and in Part A of this volume. There, we identify that no supervisor attended Portapique on the evening of April 18, 2020, to provide scene command. We find in Volume 2 that the lack of a scene commander created gaps in the initial critical incident response. These gaps meant that aspects of the response were not well coordinated, and important tasks, such as identifying eyewitnesses and flagging the need to conduct interviews, were overlooked.

LESSON LEARNED

Front-line supervisors play a vital role in policing. It is important that front-line supervisors be available to provide field supervision to general duty members and to provide scene command when needed.

Recommendation P.48

ENSURING ADEQUATE FIELD SUPERVISION

The Commission recommends that

The RCMP should ensure that general duty members in rural areas have adequate field supervision and that trained supervisors are available to provide scene command when needed. In smaller districts or detachments, this supervision may be achieved through an on-call rotation for corporals and sergeants. Risk managers, who provide remote supervision, do not fulfill this requirement.

The gap in the availability of supervisors to provide scene command was not the only failing of front-line supervision that we identified over the course of our process. In Part D of this volume, we include a more comprehensive discussion of the RCMP's approach to front-line supervision and make further recommendations with respect to everyday supervision of general duty members.

The records of the Contract Management Committee also demonstrate that contracting provinces and territories do not yet feel that the RCMP treats them as partners, gives sufficient weight to their views and priorities, or involves them in a sufficiently meaningful way in decisions that have an impact on their jurisdictions.

The Brown Task Force also raised particular concerns about the extent to which contracting partners (provinces, in the case of Provincial Police Services agreements; and municipalities, in the case of Municipal Police Services agreements) are given a voice in establishing policing objectives in RCMP contract jurisdictions:

> We also believe that there should be greater involvement on the part of provincial and local authorities in the establishment of policing objectives in the contracting jurisdictions. The Task Force heard that they are rarely a party to any discussion with representatives of the RCMP Headquarters in Ottawa in respect of policing and policy discussions which would impact their respective areas of responsibility. More often, they are simply told what has been decided.[71]

The records of the Contract Management Committee suggest that the RCMP's tendency not to include contracting partners in the early stages of its strategic decision-making persists. This tendency was identified by the Brown Task Force, the Bastarache Report, and before them by the Honourable Wallace (Wally) Oppal's BC Commission of Inquiry Report, *Closing the Gap: Policing and the Community*, in 1994.

Mr. Oppal suggested that the RCMP's centralized and militaristic structure and its institutional resistance to collaboration with other police agencies, provincial and municipal governments, and communities may mean that it is easier for British Columbia to achieve a change in policing approaches by creating a wholly new agency rather than working with the RCMP to reform its approaches. Twenty-five years later, Mr. Bastarache also came to the view that the RCMP is resistant to change, this time with respect to the prospect of reforming the RCMP's workplace culture. Mr. Bastarache accordingly concluded that "the time has come for an in depth, external and independent review of the organization and future of the RCMP."[72] He emphasized that the specific recommendations he made were "not in lieu of the independent external review that I recommend be undertaken, but can be implemented as a stop gap measure."[73]

LESSON LEARNED

Past inquiries and reviews have called for a comprehensive review of the RCMP. These recommendations have not been implemented.

Recommendation P.49

A COMPREHENSIVE EXTERNAL REVIEW OF THE RCMP

The Commission recommends that

The federal minister of public safety commission the in-depth, external, and independent review of the RCMP recommended by Mr. Bastarache in his 2020 report *Broken Dreams, Broken Lives*. In addition to examining the matters raised by Mr. Bastarache, this review should specifically examine the RCMP's approach to contract policing and work with contract partners, and also its approach to community relations.

Recommendation P.50

RESTRUCTURING THE RCMP

The Commission recommends that

After obtaining the external review recommended here, Public Safety Canada and the federal minister of public safety establish clear priorities for the RCMP, retaining the tasks that are suitable to a federal policing agency, and identifying what responsibilities are better reassigned to other agencies (including, potentially to new policing agencies). This may entail a reconfiguration of policing in Canada and a new approach to federal financial support for provincial and municipal policing services.

The third of the Brown Task Force recommendations to improve the delivery of contract policing services was that the RCMP "develop a written mandate defining the roles and responsibilities of headquarters and its relationship with its divisions."[74] The continuing need for clarity on these matters is illustrated in Part B of this volume, in our discussion of the uncertainty that arose over the respective roles and responsibilities of H Division and national headquarters regarding public communications and internal briefing practices after the mass casualty of April 18 and 19, 2020.

From our review of the RCMP's national and divisional policies, standard operating procedures, emergency operational plans, training programs, and other guidance documents requisite to our mandate, we have concluded that the RCMP's

Contract and Indigenous Policing business line[75] has failed to adopt a strategic or coordinated approach to documenting and implementing RCMP policy regarding roles, responsibilities, and expectations with respect to core policing functions. This observation applies to functions as important and varied as members' note-taking practices, supervision of a critical incident response in the period before a critical incident commander takes command, communications with the public, and the procedures to be followed when a member discharges a firearm. We found that direction about any given function was often spread across numerous policies, procedures, and other guidance documents, and that in some cases no guidance was given. In other instances, no plan existed despite the fact that policy anticipated that such plans would be routine. The volume of RCMP policies alone is overwhelming: we documented almost five thousand pages of national policy on matters within our mandate, and almost one thousand pages of divisional policy. The volume of material and the disarray in RCMP's guidance to its employees were reflected in the fact that many RCMP witnesses told us they were uncertain about which policies applied to their actions or whether relevant policies had been followed.

Policies rarely refer directly to the legal standards that would be applied to a member's work – for example, the guidance offered in case law or applicable legislation. More often, they mention the risk of internal disciplinary consequences if a policy is not followed (for example, pursuant to the RCMP *Code of Conduct*). This pattern generates the overall impression that the ultimate source of authority for RCMP employees' activities is the RCMP, rather than Canadian law. Such an impression is inconsistent with a core principle of the rule of law, which is that police powers are granted by and subject to applicable legal principles, including the Charter. This principle is expressed, for example, in the unanimous 1999 Supreme Court of Canada decision of *R v Campbell*, with respect to police operational responsibility. *Campbell* explains that the commissioner of the RCMP, "[l]ike every other police officer" engaged in an investigation, "is answerable to the law."[76]

In some instances, as with the 2015 *RCMP Sexual Assault Investigation Best Practices Guide*, the guidance offered in RCMP documents partly misstates the applicable Canadian law.[77] Such inaccuracy may contribute to RCMP members making erroneous judgments about whether a crime has been committed or whether they have authority to act in a given circumstance, as they did in the Ms. Butlin example described in Part D of this volume. In other instances, helpful documents such as guidance about critical incident response or emergency operational plans have not been kept up to date to reflect changes in relevant policy and training. Without doubt, these problems with specific documents are exacerbated by the overall volume and proliferation of guidance documents.

In December 2018, the RCMP conducted an internal audit of its policy management, focusing on "the policy development process across the RCMP."[78] This audit was the first phase in the process and focused on "the strategic planning and policy capacity within the RCMP."[79] The audit report explains:

> [P]olicy development in the RCMP is based on a hybrid model which includes a central strategic policy unit responsible for the development of policies related to government priorities. This is complemented by decentralized policy resources in Business Lines and Divisions who develop policies related to matters that are within their respective mandates.[80]

An RCMP management response observed that the audit identifies "that the number of resources contributing advice and expertise to the policy and planning functions varies across Business Lines and Divisions while also identifying that there is no consistency in how the resources are allocated and structured."[81] Of direct interest for our purposes, the audit found that the Contract and Indigenous Policing business line was responsible for 225 policies (of which 216 related to operational matters). It had 60 personnel working on policy, 33 of whom were focusing only on operational and administrative policy. By contrast, the RCMP's Federal Policing business line was responsible for 208 policies (of which 205 related to operational matters) and had 146 staff members working on federal policy, including 75 who were focusing only on operational and administrative policy.

The RCMP's 2021–22 Departmental Plan reports that the gross spending anticipated for Federal Policing in that year is approximately $890 million and that the RCMP employs approximately five thousand employees in its Federal Policing business line. By contrast, gross spending on Contract and Indigenous Policing is approximately $3.2 billion, which includes costs associated with approximately eighteen thousand employees. In short, Contract and Indigenous Policing accounts for approximately 3.5 times the budget and employee count of Federal Policing, but has less than half the personnel working on a similar number of policies. While a portion of this disparity in institutional attention to policy may be attributable to the differing work performed within these business lines, overall these numbers appear to us to reflect a tendency on the part of national headquarters to overlook how best to support the provision of high-quality, community-responsive, general policing services relative to addressing competing institutional priorities from other business lines.

Operational Spending Comparison

	Contract and Indigenous Policing	Federal Policing
Total Policies	225	208
Operational and Administrative Policies	216	205
Personnel Working on Policies	60	146
Personnel Working on Operational and Administrative Policies	33	75
Employees	18,000	5,000
Gross Spending	$3.2B	$890M

MAIN FINDING

There is a long history of efforts to reform the RCMP's contract policing services model to be more responsive to the needs of contracting partners and the communities they represent. These efforts have largely failed to resolve long-standing criticisms of the extent to which the RCMP attends to the particular needs and priorities of contract partners or addresses their expressed concerns.

LESSON LEARNED

Policies and procedures provide essential guidance to police about how to do their work. They should be clear, concise, and easily used. Police policies should be public and readily available to the public, as a principle of democratic accountability and to help the public know what they can expect when dealing with police.

Recommendation P.51

REWRITE AND PUBLISH RCMP POLICIES

The Commission recommends that

(a) The RCMP should adopt a systematic approach to policies, procedures, plans, and other guidance materials for its Contract and Indigenous Policing business line:

  (i) Existing policies should be rewritten to provide concise, evidence-based, meaningful guidance to RCMP members and employees about core functions.

  (ii) Policies and other guidance documents should reflect – and refer to – Canadian legal principles that guide the exercise of police powers. Gaps and duplication within policies should be eliminated.

  (iii) An institutional process of reviewing policies and guidance documents when training or institutional practice changes should become routine.

(b) The RCMP should post on its public website, as soon as feasible and on an ongoing basis, up-to-date copies of those policies and standard operating procedures that govern the interaction of police with the public, the manner in which policing services are provided to the public, and public communications.

(c) Where a policy or procedure or a portion of a policy or procedure is deemed confidential, the RCMP should post a public description of each exempted section and the reason why it has been deemed confidential.

Recommendation P.52

ROLE OF RCMP CONTRACT PARTNERS AND DIVISIONS IN POLICY

The Commission recommends that

(a) The RCMP should consult contract partners before and throughout the amendment or adoption of policies that affect the delivery of policing services in contract jurisdictions.

(b) RCMP divisions and detachments should be afforded sufficient resources and discretion under policy:

  (i) to consult with contract partners and community representatives about how RCMP policy will be interpreted; and

  (ii) to create operational plans, standard operating procedures, and other guidance documents, in consultation with contract partners, that reflect community resources, local policing objectives, and priorities.

In Chapter 11, we address recent discussions about the RCMP's approach to contract policing in the context of recommendations made in some contract jurisdictions to move away from obtaining policing services from the RCMP, and in others to adopt new approaches to ensuring strong community voice representation in the delivery of RCMP contract policing services. We note that Nova Scotians, too, have been discussing the RCMP's delivery of contract policing services and potential alternatives to that model. In that same chapter, we recommend that Nova Scotia should engage in a democratic conversation about possible approaches to police services for Nova Scotia communities in the future.

Valuing Rural Policing

Dr. Murphy and Mr. Corley identify that the RCMP's career model undervalues rural general duty policing, regarding that function as "the first step in careers that will bring [members] to a variety of other policing functions and locations."[82] They explain the implications of this approach for rural communities:

> As a consequence, the organization must rely on deploying new, inexperienced recruits to small communities in rural detachments. While some members adapt and do very well in rural settings, many prefer to police in more urban settings. Consequently, many have limited involvement in the local community and spend much of their off-time away. As one municipal councillor recently put it,
>
> > I do not want someone who drives in here from three hours away, works a couple days, fills a position, then throws his gear in the trunk, slams it shut and goes home, who doesn't know anybody in the community, good guys or bad guys, or if there is a hospital in Truro.
>
> … As members gain experience and opportunities for promotion, they often end up moving into different lines of police work, and particularly in rural policing, this may involve transferring to a new community. Small rural communities are thus confronted with an ever-changing cast of RCMP members, many of whom spend only a limited time in the community.[83]

Dr. Murphy and Mr. Corley identify that the trend toward combining smaller detachments into centralized locations has exacerbated the disconnect between RCMP members and the communities they serve.

Expert report writer Dr. Anna Souhami, a professor of criminology at the University of Edinburgh, prepared a systematic review of the research on rural policing for the Commission. Her report offers a nuanced discussion of the distinctive challenges of rural policing and of the common threads between rural and urban policing:

> A common theme of rural police research is the distinctiveness of the styles and skills of policing that are developed in response to the local context. In particular … research has explored how rural police work requires officers to employ a form of "soft" policing that prioritizes

> discretion, sensitivity, and responsivity to the needs of the community, transparency, and under-enforcement of the law. However, foundational police scholarship has suggested that these elements of police work are not intrinsically distinctive to rural policing but are core elements of the police role … [T]he apparently different styles of rural and urban police work arise instead from tensions between the cultural pressures within the police organisation and the different demands of urban and rural contexts.[84]

The distinctive elements that Dr. Souhami identifies include the diversity of rural police work, which arises in part from the relative lack of other community support services in rural areas which many urban residents take for granted. In our roundtable on community-based policing, Dr. Jamie Livingston, an associate professor of criminology at Saint Mary's University in Halifax, described the difference between crisis mental health services available in Halifax / Dartmouth and those offered in rural areas of Nova Scotia. Other examples were offered in our roundtables on rural policing and rural communities.

The patterns of criminal offending in rural areas also differ to some extent from those in urban areas. As Dr. Souhami explains on the basis of her systematic review:

> [R]ural areas experience some distinctive forms of crime, such as those relating to livestock and wildlife, farm and marine crime, and environmental crime. There is also a greater availability and ownership of guns, which may affect forms of offending. Issues relating to use and ownership of space (such as trespass or the policing of nomadic communities, such as Travellers in the United Kingdom and Ireland) may be particularly important in some rural areas.[85]

Given the smaller number of police officers available in rural communities, and remoteness from specialized policing services such as sexual assault investigation units or intimate partner violence specialists, rural police officers must be capable generalists who possess a good working knowledge across a range of kinds of crime and community problems. Additionally, good systems must be in place to ensure that access to specialized services is available in ways that meet the needs of rural communities, particularly underserved rural victims of gender-based, intimate partner, and family violence and race- or hate-based crimes.

Dr. Souhami points to a tension between the gains in efficiency that may be obtained from centralizing police services and the gains in local knowledge and responsiveness that may be secured by locating police in the communities they serve:

> A core issue in the organization of rural policing in all these arrangements is the balance between local autonomy and the centralization of services, and the consequences for service delivery. In particular, there are longstanding concerns that the organization of police services at a larger, centralised level may have a detrimental effect on the ability of services to respond to distinctive local needs. This issue is particularly important in relation to rural policing, as research has consistently shown the particular importance of local relationships and situated knowledge in establishing trust and legitimacy in rural areas.[86]

Dr. Souhami finds that the evidence for the claimed benefits of centralization, including improvements in the efficiency of services, is "mixed" but that "in practice, regional services that have been merged into national police forces show a decline in local policing."[87] She reports that research in numerous countries shows that centralization has "led to areas being policed by officers with little local knowledge, produced more hierarchical and centralized police service, and led the police to be seen by locals as less visible, less effective and less available locally."[88]

Dr. Murphy and Mr. Corley similarly observe that "[t]he evidence shows that the greater the physical distance between the police and the people they serve, the less satisfied people are with their police service."[89] They cite a recent study of Saskatchewan residents, which concluded:

> Rural residents were less likely than their [urban] counterparts to indicate that police did a good job of enforcing the laws, promptly responding to calls, providing information on preventing crime, ensuring their safety, or cooperating with the public to address their concerns. Findings suggest rural residents perceive their local police as being procedurally just but not particularly effective in their work. The survey also reveals that rural residents rated overall police performance poorer than their urban counterparts.[90]

In Volume 4, Community, we discuss the recent emergence of arguments in Canadian courts that the slowness of police response times in rural areas justifies the

use of firearms in a confrontation between rural property owners and alleged trespassers. Canadian law does not recognize protection of property as a legitimate reason for owning a restricted firearm, and there is an extremely narrow exception regarding the possession of such weapons for self-defence. These standards provide important safeguards against firearms violence and vigilante justice.

LESSON LEARNED

Canadian communities must be able to depend on a timely response to a call for police assistance. While the possibility of immediate response, and the nature of the response, may vary with the geographic context and the nature of the complaint, maintaining the unique responsibilities of police under the rule of law necessitates that adequate police services be provided in rural and remote communities.

Recommendation P.53

ADEQUATE POLICE SERVICES IN RURAL AND REMOTE COMMUNITIES

The Commission recommends that

Where necessary, provincial, territorial, and federal governments must provide financial support to municipalities and local communities including Indigenous communities for the provision of adequate policing services within rural and remote communities.

Consistent with Dr. Murphy and Mr. Corley's observations about promotion practices within the RCMP, Dr. Souhami notes that as European police agencies have become more centralized, "specialist units are drawn away from rural areas, officers in rural areas who wish to be promoted may feel they need to serve in these units to do so, which requires their removal from the community. Consequently, officers are incentivized to neglect local policing, risking a loss of competence in local areas."[91]

Similarly, when tensions arise between the policing priorities of the central agency and those of local communities, it is the local priorities that tend to be defeated. Dr. Souhami observes that these trends are particularly problematic when amplified by national performance management models or centralized standards that fail to account for local needs and contexts. Ultimately, she concludes that "it is not inevitable that centralized services will have a detrimental effect" on rural policing, but that care must be taken to account for local contexts and resources and to avoid imposing urban assumptions about the culture and priorities of policing on rural contexts. Her caution is echoed by expert report writer Dr. Karen Foster, Canada Research Chair in Sustainable Rural Futures for Atlantic Canada at Dalhousie University, who explained in a roundtable on rural communities, policing, and crime: "[I]t's important that we know and understand rural communities and have rural voices at decision-making tables because they are different and because if decisions are made in a centralized way, there's a greater tendency for them to have an urban bias."[92]

Both Dr. Souhami and Dr. Foster emphasize that it is also important not to generalize about rural communities because they vary greatly in their demographics, access to resources and services, and other determinants of social well-being.

Against the backdrop of this analysis, the RCMP's emphasis on centralization and standardization, and the institutional practice of treating rural general duty policing as the first step on the career ladder for members who wish to seek promotion, appears to be at odds with the delivery of policing services that are responsive to the distinctive needs and contexts of rural communities. This disjuncture becomes even more apparent when we consider the enormous variation in Indigenous cultures and communities in rural areas of Canada, and the presence of other historically and culturally distinct communities such as African Nova Scotian communities.

The RCMP offers no tangible incentives for members who wish to progress within their careers to focus on excelling in meeting the distinctive demands of rural and remote policing. Its institutional model of rotating members frequently between postings and across business lines is disruptive for communities who desire to work with members who understand the local context; indeed, this model arguably disincentivizes members from investing in community relationships. Given the proportion of RCMP contract policing services that are delivered in rural and remote communities, this practice is a significant shortcoming.

LESSON LEARNED

Rural policing is challenging work that requires a distinctive skillset. These skills should be recognized, cultivated, and rewarded, and rural police should have access to meaningful career progression opportunities within rural policing.

Recommendation P.54

REVITALIZING RURAL POLICING

The Commission recommends that

(a) The RCMP should establish an attractive career stream for members who wish to develop a specialization in rural or remote policing:

  (i) members should have the opportunity to remain in communities where they are serving effectively and where the community supports their continuation, while progressing within their careers; and

  (ii) potential leaders should also be given the opportunity to pursue further training, including higher education, on matters of particular relevance to rural policing.

(b) The RCMP should ensure that members with current operational experience and expertise in rural and remote communities are represented at all levels of decision-making within RCMP Contract and Indigenous Policing.

Recommendation P.55

COMMUNITY ORIENTATION FOR NEW MEMBERS

The Commission recommends that

(a) Every rural and remote detachment should work with its local community to prepare an orientation program for members who are new to the district.

IMPLEMENTATION POINTS

- All members transferred into a new district or detachment should complete this orientation program within six months of their assignment.
- When possible, this orientation program should include an introduction to other community safety providers such as healthcare providers and women's shelters.
- Whether such meetings are possible or not, new members should receive a package containing details about local service providers, the services they offer, and how they can be contacted when needed.

(b) The RCMP should also establish national standards for the institutional orientation that must be given to any member who transfers between divisions or districts.

IMPLEMENTATION POINTS

These national standards should address:

- completing the local orientation program;
- reviewing policies and standard operating procedures relevant to the member's area of responsibility;
- understanding local command structure, roles, and responsibilities;
- completing training with respect to local or divisional resources (such as radio and communications systems) and local culture and history (such as training programs that relate specifically to local Indigenous or African Nova Scotian communities);

- reviewing applicable legislation and bylaws including, for example, rules relating to matrimonial property on Indigenous reserves; and
- acquiring a knowledge of the local geography – for example, by attending calls and community events across the area served by that detachment.

Recruitment, Education, and Research

Throughout this Report, we have emphasized that policing agencies must be learning institutions: capable of recognizing and responding to the changing expectations of the societies and communities of which they are part, and capable of learning from their own past actions in order to do better in the future. In this section, we explain how recruitment, police education, and research contribute to the effectiveness of police services, and we evaluate the RCMP's approach to these functions.

Recruitment and "Basic Training"

In his recent book, *Canadian Policing: Why and How It Must Change*, Professor Kent Roach describes Depot, the RCMP Academy in Regina, Saskatchewan:

> Depot is proudly advertised by the Mounties as a boot camp. A promotional video starts with a scary staff sergeant telling recruits that their lives as civilians are over. This follows paramilitary traditions. Nevertheless, it is the antithesis of Peel's vision of a civilian police force that is the public.
>
> ... Depot is where the Métis leader Louis Riel was hanged. Shutting down Depot would symbolize a move away from the RCMP's paramilitary and colonial origins.[93]

The RCMP provides basic training to general duty members via a six-month residential program at the Depot and six months of field coaching in their first placement. In 2007, the Brown Task Force report, *Rebuilding the Trust*, concluded:

> Historically, the RCMP has recruited very young men and women out of high school. For many of them, their six months of initial training at the Depot is the only post-secondary education they will receive. The needs of the Force must all be met through the complement of regular members whose entire careers have been with the RCMP and who received all of their training at the RCMP. The leadership of the Force is also drawn from this group. Notwithstanding the enormous contributions that have been made by members who joined the Force on this basis, we do not believe that this will sustain the Force in what is an increasingly knowledge-based environment.

Mr. Brown and his colleagues observed a connection between the RCMP's approach to recruiting and training its members and a cultural aversion to critical engagement within the RCMP:

> The Task Force does not believe that the RCMP places sufficient value on higher education. This has the potential to rob the organization of the benefit of improving practices through exposure to new ideas and the development of critical thought. This may ultimately contribute to the difficulty the RCMP has with promoting a challenge function within its decision making processes.[94]

Their recommendations addressing these problems were not implemented.

Since that that time, further reports and studies of the RCMP have drawn a link between the current RCMP model of training and its failures to adapt to the requirements of contemporary, rights-regarding, civilian policing. Dr. Murphy and Mr. Corley summed up the conclusions of these studies as follows:

> Leuprecht, Bastarache, Maher 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.[95]

Mr. Bastarache was particularly blunt in his appraisal of the role played by Depot in what he characterized as RCMP's toxic culture:

> From what I am told, the training at Depot is intended to break a cadet down and rebuild her in the RCMP mould. It is intended to instil an *esprit de corps* based on para-military training. Unfortunately, the *esprit de corps* does not seem to extend to women, particularly on leaving Depot. I was told that a significant amount of sexualized conduct, drinking and abusive relationships between instructors and cadets occurred at Depot. Although I heard that over time, Depot had changed for the better, I still heard recent accounts of similar behaviour being tolerated or perpetrated by Depot instructors and cadets. I am of the view that the nature of the training that cadets receive at Depot contributes to the continuation of a toxic culture in the RCMP. In my view, it is time to revisit the approach of the training given to cadets at Depot and consider whether it is appropriate in a modern policing context.[96]

Mr. Bastarache recommended that RCMP recruits should be at least 23 years old and have, at a minimum, two years of post-secondary education before commencing a cadetship. Commr. Lucki and Mr. Rob O'Reilly, the RCMP's chief learning officer, expressed concern about implementing this recommendation because it may increase barriers to entry for historically marginalized applicants, including Indigenous applicants. This barrier may be a particular concern for Inuit applicants, given disparities in educational attainment levels on the part of Inuit Canadians. Commr. Lucki advised us that the RCMP Management Advisory Board has a recruitment task force and a Depot task force, both of which have been "extremely helpful." However, as previously noted, the advice given by this board is not public.

The House of Commons Standing Committee on Public Safety and National Security (SECU) also expressed concerns about the Depot model in its 2021 report on *Systemic Racism in Policing in Canada*.

The RCMP has publicly signalled some concerns about its member recruitment. A June 2020 evaluation of regular member recruitment found that "the recruitment process is not guided by an evidence-based strategy," nor does it have clear objectives.[97] This report also concluded that "[w]hile various aspects of RM [regular

member] Recruitment were frequent agenda items at SEC [Senior Executive Committee] and Senior Management Team meetings that took place during the period covered by this assessment, evidence suggests that RM Recruitment discussions took place in an ad hoc manner."[98] The report identifies that efforts to increase the proportion of applications received from women, Indigenous people, and visible minorities have not been coordinated or strategic and have not resulted in the desired gains. It also finds that suitability assessments (in which files are reviewed for the presence of red flags related to topics such as "employment" and "sexual") may not be consistently applied and that applicants were recruited despite the presence of suitability flags. The report concludes that the RCMP's focus on recruiting more applicants to fill the demand for general members in contract policing gives rise to "a risk that unsuitable applicants will be troop loaded [recruited]."[99]

Recruiting applicants with more than the minimum educational attainment of a high school diploma is not listed among the RCMP's recruitment objectives. A March 2017 RCMP report that evaluated the impact of the Cadet Recruitment Allowance (which pays a weekly salary to RCMP cadets during their time at Depot) notes that the level of educational attainment of RCMP recruits had not changed between 2004–5 and 2014–15. This report also notes that "[m]ost Cadets do not view their time in the Cadet Training Program as a form of post-secondary education. Sixty-four percent of respondents described Depot as on-the-job training compared to 23 percent who viewed their time at Depot as postsecondary education. Twelve percent described it as a mix of the two."[100]

Our Commission Participants expressed significant concern about the Depot model. Counsel for two of the families most affected by the mass casualty submitted: "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."[101] Counsel for Beverly (Bev) Beaton similarly observed:

> 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 [to] ensure public safety for Canadians …
>
> The Commission must pay attention to the correlation between society's trust in law enforcement and enhanced education and training.[102]

Counsel for the Goulet family suggested that an "increase in community trust" and "RCMP ability to attract and retain high quality recruits suitable to modern policing" should serve as metrics for evaluating the effectiveness of the RCMP's efforts to make positive cultural change.[103]

Recruitment and training were also matters on which our Phase 2 Participants made submissions. The Elizabeth Fry Society of Mainland Nova Scotia suggested that recruitment "policies should give preference to individuals with education and work experience that offer deep insights into the nature of intimate partner violence (i.e., social work, gender studies, etc.), as well as persons with lived experience."[104] Counsel for the Participant coalition comprising Women's Shelters Canada, Transition House Association of Nova Scotia, and Be the Peace Institute suggested that the Commission "call for the implementation of the recommendations in the Bastarache Report, particularly as they concern recruitment, training at Depot, human resources and staffing, grievances and discipline, and mental health."[105]

When asked about increasing educational standards for police recruits, RCMP witnesses identified that all policing agencies are experiencing difficulties recruiting suitable candidates. For example, C/Supt. Leather testified:

> [O]ver the last five years especially, it's becoming more and more difficult to recruit candidates to policing. And what's naturally occurred is the standards for entry and education in particular seems to have gone down along with that. So as the interest level has decreased, the standards have decreased as well in many ways in terms of the qualifications that we see for some of the recruits that are entering the RCMP, but not just the RCMP, other services as well. So we're a victim of our own inability to recruit, and some of the best and brightest who we historically may have attracted to policing are going into other career paths.[106]

These difficulties are also documented in the June 2020 RCMP report on member recruitment. That document identifies that the number of applicants to the RCMP cadet program dropped by approximately 20 percent between 2014/15 and 2018/19, and the percentage of rejections also dropped from 87.6 percent in 2010/11 to 66.5 percent in 2017/18. The report concludes that "suitability requirements may have been relaxed" to relieve the pressure to fill a greater number of cadet troops in the face of falling application numbers. RCMP witnesses pointed to steps being taken by the RCMP and by the Canadian Chiefs of Police Association

to address challenges with recruitment, but as C/Supt. Leather observed, "there is no magic button."[107] We consider that these difficulties are linked, among other things, to the trust deficit of community members in police generally.

The Commission heard from Dr. Kimmo Himberg, rector of the Finnish Police University College until his recent retirement. All Finnish police are educated and trained at this college. He described the relationship between police education and trust in police in the following way:

> 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.[108]

Dr. Himberg explained that the program offered at the Finnish Police University College is research-based and involves every police student in research projects. It is both a university of applied sciences that follows the standards established by the minister of education for universities and a police unit. This dual role has led to "an extremely close co-operation" between police and the university, and the university college "is deeply involved in developing policing."[109] The Finnish model was adopted in 2008, in recognition that "we cannot develop modern policing without a strong knowledge base, which is built on active research."[110] Dr. Himberg described the objectives of the Finnish model: "[T]he ultimate goal on this is that we want to build the police service which is efficient, able to adapt to … changes in the operative environment and a police service, which enjoys high-level trust by the citizens."[111] This objective is also reflected in the Finnish approach to recruiting police students:

> We believe that "modern policing" as a profession is such a complicated spectrum of skills and knowledge needs that we need to have an extensive education which combines theoretical and practical aspects.

> I wish to mention that we are also extremely careful in selecting our students through several psychological test sets and interviews. We definitely do not want, as an example, Rambos, Rockys. We want young people who are able to take initiative, make independent decisions, who have the characteristics for this so that we can build the education on those characteristics.
>
> But once again, I would like to emphasize the importance of research-based knowledge here.[112]

The Finnish model allows recruiters to assess the suitability of potential police students when they apply to the Finnish Police University College. Then, over the course of the education program, there is a three-year opportunity to further assess candidates' suitability before they work in communities as a police officer. This approach maximizes the quality of candidates recruited for police education, while also ensuring that graduates of the program are both well prepared and temperamentally suitable for work as police officers.

Dr. Himberg offered an example of the Finnish Police University College approach to educating future police, describing how the Finnish model approaches "use of force training" (as this training is commonly termed in Canada):

> [U]se of force is built on police ethics and police legislation, and national police board orders. So the technical skill comes somewhere very far after we have gone through several stages of teaching the theories of ethics and law.
>
> … It is important to emphasize that the responsibility of acting properly is on an individual officer. And if you allow me to refer to [the] Finnish *Police Act*, which is the most important piece of legislation that we have, immediately in the beginning of the Act, of course, the law emphasizes the importance of respecting fundamental and human rights, and the law says that in exercising police powers, the police [officer] has to choose from all reasonable options the course of action that best asserts these rights. And then the law presents three important principles.
>
> Principle of proportionality, so the police action has to be proportionate with regard to the important danger and urgency of the duty …
>
> [The] second principle is principle of minimum intervention. The law says that the police shall not take action that infringes anyone's rights or

> causes anyone harm or inconvenience more than is necessary to carry out their duty. Once again, the law states that the police [officer] to keep calm and to use a minimal amount of action, a minimal amount of power, and once again, the responsibility is on the individual officer.
>
> Third principle is principle of intended purpose, so the police may exercise their powers only for the purposes provided by law. This is, of course, important because an individual officer may never, by law, act unless there is a legal ground …
>
> I will read one more sentence from the Act. The police shall seek to maintain public order and security primarily through advice, requests and orders. This illustrates that the purpose, **the aim of policing in my country is to avoid using force always when it is possible to avoid the use of force. And if there is a situation where there is no alternative, then use a minimum amount of force.**
>
> Now you understand that the calmness, the ability to make decisions in stressful situation, it cannot be trained in short training courses. It has to be built step by step so that also the attitude and value basis is strong enough in the young police officers.
>
> … Also, those citizens who have alcohol problems, drug problems, mental health problems, who are agitated because of some particular reasons, they – as the law implies, it is the police who [have] to bring in the calmness into the situation.
>
> I will add one last thing. You use the term de-escalation. To me and to us, de-escalation is a very curious concept, because it contains the idea that the situation has escalated, and then it has to be calmed down. Our way of thinking is the opposite. We try to avoid the escalation of the situation at all costs.[113]

The success of the Finnish model of education is reflected in the public trust enjoyed by Finnish police, but also in the statistic that in 2020, Finnish police shot a total of two times at target persons, and in 2021, they shot seven times at target persons. No person was killed by Finnish police over this two-year period. Finnish police use this approach of minimum force even when intervening in a mass casualty.

Recalling the revised principles of policing described by Dr. Ian Loader, a professor of criminology at the University of Oxford, and recommended for adoption in Chapter 9 of this volume, the Finnish approach supplies a model of police education and the legal codification of police responsibilities. Operating together, they ensure that the police function in a way that minimizes the harms associated with the legal permission to use force while maximizing the police capacity to contribute to social cohesion and treat others respectfully. Built on evidence-based principles and respect for human rights, the Finnish approach to educating police students has achieved remarkable success in two key indicators: public trust and capacity to avoid the use of lethal force.

Implementing the Finnish model in Canada would entail a certain amount of complexity given Canada's federal structure and the patchwork of federal, provincial, and municipal police services. However, this complexity can be managed with a co-operative approach. We urge federal, provincial, and territorial ministers and police services to work together to establish national standards for a common, university-based approach to police education. Adopting a national approach will be the most cost-effective solution. It will also address concerns we heard expressed by some RCMP witnesses that one impediment to interoperability between the RCMP and municipal police services is concern about differences in training approaches between these agencies.

Continuing Training and Research

The RCMP offers most of its continuing training in house. Some specialist training is offered by the Canadian Police College – a national police service offered by the RCMP.

The Participant coalition of the East Coast Prison Justice Society and the BC Civil Liberties Association cautioned the Commission against making recommendations for extra police training without attending carefully to the value of training: "When resources are directed to enhanced training in response to police failure, there are limited procedures in place to ensure that training is effective and that it translates into positive outcomes for the public."[114] Dr. El Jones, an assistant professor in political and Canadian studies and cultural studies at Mount Saint Vincent University in Halifax, explained in a roundtable on contextualizing critical incident response:

> [D]espite all the resources that we often want to put towards training and say the number one thing we need is more training, we have no data on it, we don't evaluate the training, we don't actually have any process for externally reviewing that training, so tracking that it's being taken. And there's really no evidence that any of the training that we recommend actually has an impact.
>
> And what it does do, of course, is further put resources into policing, and we end up with more and more resources going unaccountably into the police.[115]

Moving to the Finnish model of police education has the advantage of establishing a set of institutions – police universities – with the mandate to study the effectiveness of training programs and approaches and the ability to offer evidence-based continuing training. In our roundtables, we heard from Canadian academics Dr. Judith Andersen, associate professor of psychology, and Dr. Paula Di Nota, a researcher, both at the University of Toronto, who have been collaborating with the Finnish University Police College in their research on the impact of stress on police decision-making. They are working with this college because of the opportunities afforded by Finland's research-based approach to police education and training.

In Finland, Dr. Di Nota explained, they have found "this very open team environment where police practitioners, the use of force instructors were an essential part of that team in informing the development of training, and were very receptive and very open to listening to what we have to say."[116] She observed that in Canada there is "a break in the chain somewhere between evidence, the evidence base and then the implementation of that into practice seems to be broken here, largely, not just in Ontario, not just in Canada, but also in the United States."[117] Supt. Wallace Gossen of York Regional Police similarly reflected that in Canada, "very little research … has filtered into our [police] community for us to be able to use."[118]

In a roundtable on contesting critical incident response, Dr. Anderson, Dr. Di Nota, and other academics who conduct applied research into critical incident decision-making and the impact of stress on police decision-making exchanged insights with Dr. Himberg, Supt. Gossen, and Deputy Chief Stephen MacKinnon of Cape Breton Regional Police. This discussion illustrated the potential of research-based approaches to police education, including specialist education such as that given to critical incident commanders and emergency response teams. This potential is presently almost entirely untapped by the RCMP.

One key message that emerged from this session is that effective police decision-making under highly stressful conditions is a skill for which police can be trained. Police will perform this responsibility most effectively when they have a foundational understanding of their ethical and legal responsibilities to the community, when they practise remaining calm in stressful situations, and when they are taught systematically, using techniques that draw on a range of research areas from physiological research on the effects of stress to psychological research on effective decision-making.

When police training for use of force focuses on tactical and manual skills while overlooking these other dimensions, both the police and the public are disserved. Dr. Andersen explained that some research suggests that decontextualized, tactics-focused use of force training actually increases the frequency with which police use force:

> [W]hen use of force training, the one or two days of training that police officers were getting per year was focused only on weapons and tactics, how to use your weapon, how to use different tactics, and so forth, there was more of a tendency to rely on use of force options at every call. So it became more likely that they would go to a use of force option right away and then use it.[119]

Dr. Andersen explained the causes of this effect: "[I]f use of force training or the one annual training that you get is not proportionally focused on the kinds of calls that you see, you're going to have an inflated sense of risk when you go to every call, and that this is borne out in theory of risk as well as the data."[120] In response, Dr. Himberg asked, "What kind of training is that? Shouldn't training in use of force rather improve the decision-making abilities" of a police officer?[121]

In 2007, the Brown Task Force observed a lack of openness to research within the RCMP. The Brown Task Force noted that the RCMP had then recently eliminated its research and development branch of the Canadian Police College. It recommended that the RCMP "rebuild its research capability in order to provide members of the Force with an opportunity to explore developments in law enforcement outside the RCMP and stay abreast of modern policing methods."[122] Throughout our process, we observed the impact of the RCMP's institutional lack of attention to research and best practice in other police services and other jurisdictions. For example, it became apparent that the national critical incident program at RCMP headquarters does not collect and review reports on critical incident responses

in other jurisdictions, nor does it systematically monitor research being published by bodies such as the Advanced Law Enforcement Rapid Response Training (ALERRT) Center at Texas State University. This institutional gap impairs the operational effectiveness of the RCMP and has resulted in its critical incident preparedness lagging behind international best practices.

Dr. Benjamin Goold, a professor at the Allard School of Law at the University of British Columbia, is a police ethnographer who moved some years ago from the United Kingdom to Canada. He observed on the basis of his research experience that Canadian police services are, for the most part, less open to research partnerships than their counterparts in Britain:

> [T]he best point of comparison for me is with the United Kingdom … There was a considerable openness to academic research. It wasn't always easy to get access, they were often involved in long processes of negotiation, ethical questions being raised on both the university side and what was the policing side. But my sense was there was an openness to that relationship, and certainly I observed a respect for academic researchers in many police services that I worked with; even if I wasn't always confident that they would take what we were writing on face or necessarily adopt the recommendations we might make, there was an openness to the possibility of independent research.
>
> … I was struck when I came to Canada that that didn't seem to be the culture; that it was my observations when I arrived here was it seemed to be very difficult to get access to police services in Canada to do the sort of work that I had come to see as sort of crucial when I was working in the United Kingdom.[123]

Dr. Andersen described her experience of seeking to bring her research insights, which she had gathered through her work with the Finnish University Police College, back to Canada:

> [W]hen I had data, I came back to Canadian police and that's when they started, their couple of chiefs were, "Okay, we'll do this here." And then when I went into the use of force office to – in the different services to even do our research and ask for their assessments, "What's your use of force assessment form look like?" "Oh, well, we don't really have" – you know? And it was like, "Well, we'll just pass this person along." …

> [E]ven with something as high buy-in as the physiological data, where they can see the change and see the results, we've had services implement this and take it right through, like Finland, right through from recruits all the way to their federal forces, and it's in the culture, it's in the language, and it's used, to other services in Canada where, you know, after we leave and the training material is there, they turn it into a 15-minute PowerPoint and then it's a checkbox and it's gone.[124]

Dr. Andersen's remarks resonate with our observations of the RCMP's response to the recommendation in the 2014 MacNeil Report in regard to mandatory training for supervisors in initial critical incident command. This recommendation, which is marked by the RCMP as implemented, was addressed with a 90-minute online training course (see Part A of this volume). Even with this minimal requirement, the majority of front-line supervisors who responded to the mass casualty had not completed this ostensibly mandatory course.

The RCMP's failure to embrace a research-based approach to program development and police education and its lack of openness to independent research impairs its operational effectiveness.

MAIN FINDING

The Depot model of police training is inadequate to prepare RCMP members for the complex demands of contemporary policing, and the RCMP's failure to embrace a research-based approach to program development and police education and its lack of openness to independent research impairs its operational effectiveness.

LESSON LEARNED

The existing Canadian standard of police training outside Quebec is inadequate to equip police for the important work they do and for the increasingly complex social, legal and technological environment in which they work. The shortcomings produced by this approach have a disproportionate adverse impact on those who have historically been underserved by police.

Recommendation P.56

MODERNIZING POLICE EDUCATION AND RESEARCH

The Commission recommends that

(a) The RCMP phase out the Depot model of RCMP training by 2032 and the RCMP consult with the Métis and Saskatchewan Federation of Sovereign Indigenous Nations with respect to how the land and the facility should be used in the future.

(b) Public Safety Canada work with provinces and territories to establish a three-year degree-based model of police education for all police services in Canada.

IMPLEMENTATION POINTS

- Implementing police education programs may entail partnering with existing institutions of higher education, and will require collaboration between ministries of higher education and research and federal, provincial, and territorial ministers responsible for policing.
- The new model of police education should be research-based, allow students the opportunity to participate in research, and lead candidates to a three-year bachelor's degree in policing.
- Attention should be paid to ensuring that the new model is accessible and culturally responsive to women, Indigenous students, and other groups that have historically been underrepresented in and underserved by police in Canada. Offering financial support to qualified candidates from these groups may help to attract a more diverse group of policing students. The new police education model should adhere to national standards, but it should be offered on several campuses in different Canadian regions. These campuses will likely be affiliated with existing universities or colleges.
- Ideally, at least one campus should be established in the Atlantic region and one in northern Canada.
- Public Safety Canada should consult with the Finnish Police University College and Finnish Police in the design of this program.

(c) Public Safety Canada and the RCMP should integrate the Canadian Police College into the new police university system subject to the same governance as other institutions in that system.

(d) Responsible ministers and police boards should issue written directions to police services to collaborate with universities on research and programming and in the development of evidence-based policies and procedures.

Recommendation P.57

USE OF FORCE

The Commission recommends that

The Government of Canada and the RCMP should replace the existing use of force provision in the RCMP *Code of Conduct* with the principles set out in sections 2 to 9 of the Finnish *Police Act*.

Management Culture

In her expert report, "Police Culture: Origins, Features, and Reform," Dr. Bethan Loftus, senior lecturer in criminology and criminal justice at Bangor University in Wales, observes:

> Police officers and the organizations they are part of are not insulated from broader political, social, cultural, and economic contexts … Chan reaffirmed the importance of examining the interactions between the "field" (the wider organizational, historical, legal, socio-economic, and political conditions of police work) and the "habitus" (the informal norms and values of officers). For Chan, police culture arises from the intrinsic

> relationship between the field and the habitus, such that when transformations in the field of policing are not accompanied by changes in the habitus, real reform will remain limited.[125]

In this report, Dr. Loftus draws on the work of Australian criminologist Dr. Janet Chan to explain the interplay between police culture and the political, social, cultural, and economic context of policing. Dr. Chan and Dr. Loftus state that the impact of police reform will be limited unless the informal norms and values of police change to accommodate the objectives of that reform.

In short, the culture of a police service can have a determinative impact on the success of attempts to reform the organization and how it does its work.

Dr. Loftus explains that efforts to reform police – for example, by implementing recommendations made by public inquiries – can have complex results when they are filtered through the informal norms and values of police organizations:

> Researchers from different jurisdictions have demonstrated that aspects of police culture are in transition and can respond positively to change. One sticking point, however, is the question of whether changes deliberately brought in to alter the most negative manifestations of police culture are likely to prompt change at only superficial rather than entrenched levels. As Marks has argued, meaningful police transformation must encompass not only structural and behavioural changes but also *attitudinal* shifts.[126]

In this section, we focus specifically on management culture within the RCMP. By management we are again referring to commissioned officers, which in the RCMP means those sworn members who hold the rank of inspector, superintendent, chief superintendent, assistant commissioner, deputy commissioner, and commissioner. We also include civilian employees who hold equivalent ranks.

Dr. Holly Campeau, a professor of sociology at the University of Alberta, explained in her expert report that the term "police culture" has frequently been given a "static and one-dimensional" meaning within policing studies in the form of a list of typical characteristics or a "work personality" ostensibly shared by many or most police officers. There is value in this work: for example, Dr. Campeau points to research that identifies the operation of a "code of silence" among police, an "unwritten rule of police behaviour that constrains an officer from informing on or testifying against another officer … animated by intense loyalty to the group, and

mutual protectiveness against outsiders."[127] She further explains that police culture is better understood as a "'repertoire' of *resources* that are deployed in order to bring justification to their experiences."[128] When understood in this way, the more useful approach is to look closely at the norms or practices used by RCMP management, particularly in moments of conflict or uncertainty, to "produce cultural meaning about their work."[129] Looking for these norms or practices, for example, we are attentive to evidence about how RCMP managers made sense of criticisms of the RCMP's work during and after the mass casualty as information about how the RCMP's management culture operates in times of crisis.

We are particularly focused on management culture because, if the RCMP is to make the significant changes we call for in this Report, the work of leading this change and of bringing other RCMP members into this change will be led by commissioned officers and their civilian equivalents. As Dr. Murphy and Mr. Corley explain in their expert report, RCMP leaders' commitment to and capacity for leading change has been questioned in studies, reports, and in internal RCMP discussions.

If the RCMP's management does not share a commitment to making this change – or worse, if some members of management actively work to undermine efforts to reform the RCMP – these efforts will likely fail. According to the RCMP's website, its current strategic plan, "Vision150 and Beyond," "strives to prepare the RCMP for the future and advance our modernization objectives, thereby ensuring we are a world-class police organization." Former Commr. Lucki characterizes "Vision150" and its four pillars of culture, people, stewardship, and policing services as "the roadmap for RCMP modernization." The strategic plan includes, as a priority, "[m]oderniz[ing] RCMP leadership, including advancing character leadership."[130] The term "character leadership" is not defined, but the plan states that "[p]aramount to the long-term success of the RCMP is a focus on providing training and professional development aimed at improving job performance, leadership and sensitivity to biases, enabled by technology and development processes."[131] The strategic plan ranks as "high" the risk that "the RCMP will be unable to adequately attract and retain diverse groups of employees with the appropriate skills, attributes, characteristics and mindset to police the crimes of the future."[132] It ranks as "medium" the risk that "the RCMP will encounter resistance and obstacles in the realization of transformative efforts to support policing of the future."[133] However, it does not specify whether such risks are internal or external. The strategies and approaches that the RCMP is employing to pursue these priorities and address these risks are not published on the RCMP's website.

To observe that management culture is crucial to effectively making change is not to diminish the role and importance of all RCMP members and employees in this endeavour. The research suggests that "when rank-and-file officers are centrally and democratically involved in change processes, there can be a measure of success."[134] However, management culture also determines the extent to which organizational change brings other members of the organization into the change process and allows them the space to reflect and contribute.

Earlier in this chapter, we set out the conclusion of the Brown Task Force that the RCMP's management culture discourages leaders from taking responsibility for conveying bad news up the chain of command and from making decisions that may be criticized. We identified evidence in our proceedings that suggest the continuing operation of this tendency today.

The 2020 Bastarache Report added to the Brown Task Force's conclusions and to the discussion that we have so far provided by identifying a particular concern about the RCMP's culture with respect to women managers:

> Even when they are promoted, women are not always given the same respect as their male colleagues. We were told of numerous incidents in which a junior member questioned and refused to follow the orders of a woman of superior rank. **Even when such behaviour was raised with a more senior male officer, it was often disregarded or worse tacitly approved.**[135]

Mr. Bastarache explained that these concerns were exacerbated by a tendency to promote women into administrative roles, when they are promoted, rather than into operational supervisory roles. Further evidence of a bias in the allocation of leadership roles and responsibilities is provided by a June 2022 report prepared by the RCMP National Program Evaluation Services with respect to in-service training. (In Volume 3, Part B we defined bias as any systematic factor that might affect the outcome of an assessment other than the truth.) This report found that only 6 percent of tactical training instructors and 0 percent of Emergency Response Team / Underwater Response Team / Officer Safety training instructions were women. By contrast, 33 percent of instructors in mandatory non-tactical courses were women. The report also documents that "[s]ome survey respondents reported that [a gender analysis] is irrelevant in a training environment."[136] This tendency to stream women out of tactical and operational leadership is not unique to the

RCMP: Dr. Campeau supplies a summary of the research on the challenges faced by women in policing as they navigate their identities as women and as police.

Toward the end of our proceedings, we received evidence of an interpersonal dispute in H Division that demonstrates the persistence of the dynamic that Mr. Bastarache described. In Volume 2, What Happened, we document conflict arising between the Emergency Response Team and H Division leadership in the aftermath of the mass casualty. Members of the Emergency Response Team requested that part-time members be released from their general duties for a period of two weeks so the team could spend time together, address equipment issues, participate in critical incident debriefings, and access peer support. This request was not granted, though, consistent with the overall pattern we observed of RCMP decision-making, it does not seem to have been specifically rejected – it simply lapsed with the passage of time. Cpl. Timothy (Tim) Mills explained his understanding of how this incident played out both in his testimony and in his Commission interview. Based on this perception, he had filed a formal request that Ms. Kelly Sullivan, the H Division employee management resource officer, be internally investigated for a *Code of Conduct* violation. It is apparent from Cpl. Mills's evidence that he believed Ms. Sullivan had not supported the Emergency Response Team members' request for a temporary change in their assignments, despite having told them she would do so. Cpl. Mills was sharply critical of Ms. Sullivan's personal integrity and management style.

On October 26, 2022, after the close of our public proceedings, the Commission accepted a letter from independent legal counsel for Ms. Sullivan and an affidavit affirmed by Ms. Sullivan. This affidavit provided considerably more information about the course of H Division leadership decision-making with respect to the Emergency Response Team members' request. It records that Ms. Sullivan had concluded the request was in accordance with best practices, but she was advised by her supervisor that it was not within her authority to grant it. Rather, "[a]ny such decision was one for the chain of command."[137] She sought to raise the matter with C/Supt. Leather and had discussions with Supt. Darren Campbell in which she made it clear that she supported the request but, because granting it was not medically required, only the operational supervisors could make this direction. In a subsequent meeting with several members of H Division leadership, Ms. Sullivan reiterated that granting the request "would be advisable for wellness," and A/Commr. Lee Bergerman directed that part-time Emergency Response Team members be relieved from their regular duties for 14 days and allowed to work with full-time members. Ms. Sullivan understood that this direction would be conveyed

by C/Supt. Leather to Supt. Campbell and, from him, to the Emergency Response Team members. However, unbeknownst to her, this direction was not followed.

Ms. Sullivan's affidavit documents a chain of correspondence in late April and early May 2020, culminating in her suggestion, made in early May, "that we should organize a meeting with the ERT members to resolve the matter and clarify any further misunderstandings."[138] Supt. Campbell agreed with this strategy and offered to facilitate the meeting. However, the meeting did not transpire.

In late May and early June 2020, Ms. Sullivan became aware that "disparaging and derogatory remarks were being made" about her by members of the Emergency Response Team. Some of these comments "were sexist in nature."[139] She called Supt. Campbell to report this information and demanded a meeting "to 'clear the air.'"[140] Supt. Campbell responded to the effect that "the boys had been having a rough go" but assured her again that he would arrange a meeting. Ms. Sullivan persisted in her requests for a meeting over the ensuing weeks, and Supt. Campbell and C/Supt. Leather expressed their support for this idea, but no meeting was ever scheduled or held.

In September 2021, Supt. Campbell advised Ms. Sullivan that Cpl. Mills had requested that a *Code of Conduct* investigation be conducted against her. He also advised her, for the first time, that the part-time Emergency Response Team members had not been relieved of their general duties in April and May 2020, contrary to Ms. Sullivan's recommendation and A/Commr. Bergerman's direction. Ms. Sullivan continued to seek a meeting with Emergency Response Team members, in part to explain that she had no role in granting the kind of accommodation they had requested.

When Ms. Sullivan learned that "false and slanderous statements" had been made about her in the Commission's proceedings, she "followed up with Department of Justice counsel [for the RCMP] and tried to explore this issue with management."[141] On August 23, 2022, Insp. Donald (Don) Moser sent a document to Emergency Response Team members clarifying that "[a]t no time has the EMRO [Ms. Sullivan] had a role in approving such requests or determining ERT operational requirements."[142] Insp. Moser also reminded recipients of "the importance of treating one another with respect" even in "highly charged and stressful times."[143] The RCMP produced a copy of this document to the Commission but did not explain that it related to Cpl. Mills's evidence or that a correction to that evidence was necessary. Eventually, Ms. Sullivan received indemnification to retain independent counsel in order to correct the record herself. In Ms. Sullivan's affidavit, she reflects: "It is very

upsetting to me that management allowed this misunderstanding to fester for over two years. These members endured serious and traumatic events and deserved better."[144]

Participants, including the RCMP, were given the opportunity to tender evidence, including affidavits, in response to Ms. Sullivan's affidavit. They did not do so. We accept that the decision-making with respect to the Emergency Response Team's request played out as Ms. Sullivan describes in her affidavit and as A/Commr. Bergerman described in her testimony. We acknowledge, as A/Commr. Bergerman identified, that resource constraints likely played a role in the failure to implement her direction that the Emergency Response Team members' request be granted. For present purposes, however, we are more concerned with how this evidence illuminates three aspects of the RCMP's management culture.

First, Ms. Sullivan's affidavit provides specific evidence of an instance in which sexist and derogatory comments were made about Ms. Sullivan, a woman in a management role, and brought to the attention of more senior male leaders, but this sexism was not addressed. Insp. Moser's communication, which was sent more than two years after these events took place, provides a general direction to be respectful in professional communications but does not name or counter the operation of discrimination. If the toxic culture identified by Mr. Bastarache is to change, sexist and derogatory comments must not be overlooked. Male leaders in operational roles have a particular responsibility to address these behaviours in a timely manner whenever they are brought to their attention. We find the excuse initially offered – that "the boys had been having a rough go" – particularly troubling in its justification of expressions of sexism within the exclusively male environment of the Emergency Response Team and its implicit assumption that a female manager in a human resources role does not have legitimate expectations that she will be treated fairly and respectfully by operational members.

Second, for more than two years, male leaders in H Division allowed misinformation to circulate about Ms. Sullivan's work and responsibilities, despite her constructive efforts to address that misinformation and repair relations with the Emergency Response Team. The failure on the part of operational leaders to acknowledge their responsibility for not relieving part-time Emergency Response Team members of their general duties, and the failure to explain to them why this accommodation had not been made even after Ms. Sullivan asked that misinformation be corrected, constituted an institutional betrayal of Ms. Sullivan by the RCMP. It was unhelpful to the Emergency Response Team members, who spent more than two years blaming

the wrong person and building a narrative about this decision that focused on the wrong issues, and detrimental to the H Division team as a whole.

In an academic article cited in the Avalon Report, Professor Emily Suski of the University of South Carolina School of Law explains that an institutional betrayal arises "when an individual trusts an institution to help in the face of trauma, but the institution fails to help."[145] The phrase "institutional betrayal" is not used in the 2020 Bastarache Report, but it documents a pattern of institutional betrayal of women employees who complained about harassment and discrimination on the part of the RCMP.

Noting the RCMP's public commitment, made in November 2020, to address the culture documented by Mr. Bastarache, we are troubled by the failure of H Division leaders to recognize and discharge their responsibilities to Ms. Sullivan. Their failure to address her concerns was, in turn, compounded by the RCMP's failure to correct the Commission record, which culminated in Ms. Sullivan's submission via independent legal counsel to the Commission.

Finally, we have received no explanation for why A/Commr. Bergerman's direction to grant the accommodation was not implemented. Nor do we know why no one told A/Commr. Bergerman and Ms. Sullivan at the time that the direction had not been followed.

Three other specific areas in which we identified the persistence of management attitudes that have the potential to thwart institutional change arose in relation to the report prepared by the Quintet Consulting, *Wellness Assessment*. We discuss this report in Part B of this volume in the context of the continuing impact of the RCMP teleconference of April 28, 2020, on those who attended that meeting – all of whom were senior members of national headquarters and H Division staff. This report was commissioned by national headquarters in response to concerns about the morale and well-being of H Division leadership. Of 26 eligible individuals, 24 commissioned officers and their civilian employee equivalents participated in this assessment.[146] The report explains that employees were interviewed individually using "open-ended questions on morale, well-being, workplace culture, job satisfaction, helping resources, and future considerations."[147] The authors emphasize that the value of the study lies in the opinions expressed by those who were interviewed and that "Quintet did not investigate the veracity of the issues raised nor evaluate the credibility of those interviewed."[148] We have taken the same approach. We draw on the Quintet Report as evidence of the opinions and

attitudes expressed by those interviewed, and not as evidence that the incidents or conduct reported by interviewees in fact occurred.

The report authors identify that there "was a high degree of emotion among many of the participants," including anger and visible distress.[149] All those interviewed mentioned the mass casualty as "impactful and many described it as the lens through which they now define their lives and their careers as changed."[150] The report explains: "Above all, the participants made it abundantly clear that they wished their candid messages to be heard and that they expected meaningful action to result."[151] As we explain in Part B of this volume, despite this clearly expressed wish, the report languished in national headquarters for months after it was sent to the RCMP.

The first issue of concern with respect to the Quintet Report is the fact that it was not shared with Commr. Lucki or senior leaders in H Division for several months after it was delivered to D/Commr. Brian Brennan and Ms. Gail Johnson, the chief human resources officer. We did not receive a clear explanation for this failure to share this report with Commr. Lucki and other senior leaders. The decision not to share this document appears contrary to the stated priority in "Vision 150" of fostering a culture that promotes mental health and well-being. The report documents serious concerns about the morale and well-being of H Division leadership, and it warranted immediate attention and careful review by members of the RCMP Senior Executive Committee and H Division leaders. The failure to share the report may fit within the pattern identified by the Brown Task Force in which managers are reluctant to share bad news internally. However, the silence and lack of action was contrary to the expectations of those H Division leaders who had participated in the review.

The second issue of concern relates to statements made by interviewees about the leaders of other police services in Nova Scotia, including statements about the character of those leaders. The members who were interviewed suggested that the relationship between the RCMP, the Province of Nova Scotia, and some municipal police services was "dysfunctional … [and] a constant drain on their professional and personal resources, causing stress and anxiety."[152] We similarly heard evidence, from RCMP witnesses and others, that relationships between the RCMP and some police services, and between the RCMP and the province, had become particularly strained after the mass casualty. Some of this evidence is documented in Part B of this volume.

Witnesses offered a variety of explanations for these difficulties. For example, A/Commr. Bergerman attributed primary blame to municipal police services: "I believe and it was apparent that it became popular to distance yourself from the RCMP because we were receiving a lot of criticism publicly and there were – there were times when there was an opportunity that certain Chiefs would publicly say negative things, so that's – that was the start of it."[153]

A/Commr. Bergerman acknowledged that there were "personality conflicts with some of the chiefs and some of our members."[154] She also noted that after the mass casualty, "the negative press was very traumatic" for many in H Division.[155] The negative impact of the mass casualty and succeeding events on the well-being of many H Division leaders is well documented within our record, including in the Quintet Report. For present purposes, **we note that some of the strategies adopted by H Division leadership to cope with the spotlight that was placed on the RCMP and its response after the mass casualty suggest a lack of positive cultural resources within the RCMP for dealing with conflict and criticism.**

In this instance, RCMP leaders interpreted public criticism by their peers as opportunistic or unprofessional, rather than, for example, viewing this criticism as an invitation for self-reflection or self-evaluation. The Quintet Report, and the evidence we heard from RCMP leaders about the interpersonal difficulties between RCMP management and municipal police chiefs, led us to conclude that effective conflict resolution skills are not consistently cultivated or valued within the RCMP's management culture. The undervaluation of these skills is similarly apparent in how H Division leaders and personnel in national headquarters dealt with conflict between H Division and national headquarters after the mass casualty. In addition to meaning that conflict tends to become entrenched, the cultural tendency to respond to criticism by impugning the motives of the person who made that criticism impairs the RCMP's capacity to recognize and learn from its mistakes.

LESSON LEARNED

Conflict management is an essential skill for all police officers, but especially for supervisors and managers.

Recommendation P.58

CONFLICT RESOLUTION SKILLS

The Commission recommends that

(a) The RCMP make in-person conflict resolution training mandatory for all RCMP members before promotion to the rank of staff sergeant or above, and before promotion to an equivalent civilian position.

IMPLEMENTATION POINT

The RCMP should contract with an external training provider that has an established track record in delivering effective conflict resolution training until such time as a culture of conflict resolution becomes engrained and its internal capacity to deliver effective internal conflict resolution training is established.

(b) The RCMP make demonstrated conflict resolution skills a criterion for promotion to all RCMP leadership positions.

This chapter is dedicated to the future of the RCMP, and this recommendation addresses only that institution. In Chapter 11, we identify that responsibility for the conflict that lingered between H Division leadership and other Nova Scotia police leaders does not rest solely at the feet of the RCMP. We therefore make further recommendations in that chapter with respect to conflict resolution.

The third issue of concern that arises from the Quintet Report relates to comments made by H Division leaders about Commr. Lucki's acknowledgment that systemic racism existed in the RCMP. This acknowledgment came in mid-2020, in response to an intense public focus on police racism. George Floyd, a Black man,

was murdered by a police officer during an arrest in Minneapolis, Minnesota, in May 2020. After Mr. Floyd was killed, widespread public attention was focused on the operation of systemic racism within police forces, including in Canada. Commr. Lucki was asked by Canadian media whether systemic racism exists in policing in Canada, including in the RCMP. After initially equivocating, she issued a press statement dated June 12, 2020, in which she said:

> During some recent interviews, I shared that I struggled with the definition of systemic racism, while trying to highlight the great work done by the overwhelming majority of our employees.
>
> I did acknowledge that we, like others, have racism in our organization, but I did not say definitively that systemic racism exists in the RCMP. I should have.
>
> As many have said, I do know that systemic racism is part of every institution, the RCMP included. Throughout our history and today, we have not always treated racialized and Indigenous people fairly.
>
> Systemic racism isn't about the behaviour of a single individual or the actions of one person. It's in the institutional structures that reflect the inequities that persist in our society. And it shows up in policies, processes or practices that may appear neutral on the surface, but disadvantage racialized people or groups.
>
> As an organization, we work hard to address this, to overcome it – we incorporate the lens of diversity and inclusion in our decision-making, in our training, in our recruitment. It has allowed us to better understand some of the unintended barriers that exist, and to work to correct them.
>
> ...
>
> I appreciate the frank discussions that have been taking place and I have encouraged all employees to have the conversations that some may find uncomfortable. But I have been told that struggles and discomfort are one of the hallmarks of addressing racism.[156]

Dr. Campeau observes that police management "must be attuned to the political, social, and economic constraints that exist outside the police organization and how these impact the daily operations of the department."[157] The public debate around the operation of systemic racism in Canadian police services represents a

particularly direct example of that dynamic. In the glare of media scrutiny, Commr. Lucki and other senior RCMP managers grappled with how best to respond:

> I struggled with the definition of systemic racism. Then, after the big backlash in the media, I went back to people like Gail Johnson, who was our CHRO [chief human resources officer], and Nadine Huggins, who worked for Gail Johnson, we had lots of discussions at the Senior Executive Committee level, you know, and it was understanding what it meant in the context of the RCMP.[158]

Commr. Lucki explained that her statement of June 12, 2020, was issued as a result of these internal conversations.

The authors of the Quintet Report explain:

> A significant number of participants stated that they were personally hurt when the Commissioner said that systemic racism existed in the RCMP. They said that this was clearly a "politically motivated" statement, but unless it was better explained, it made every Member feel like they were being accused of being racist. One said, "She threw us all under the bus." A few noted that it put their colleagues who were Black or Indigenous in an internally conflicted situation, wondering whether they themselves were part of the problem.[159]

This summary of the Quintet interviews suggests that the senior officers who spoke to this issue had not read Commr. Lucki's statement, which distinguishes individual racism and defines systemic racism in a manner that makes it clear it is not conscious discrimination or a direct reflection of individual beliefs.

The senior officers' stated regard for the impact of acknowledging racism on Indigenous and racialized colleagues also suggests that those who spoke to this issue do not appreciate that many Indigenous and racialized police have lengthy experiences of racial discrimination, including racial discrimination in their working lives. Commr. Lucki's statement is highly unlikely to be the first time these members have considered how racism operates. Dr. Jane McMillan, chair of the Department of Anthropology at St. Francis Xavier University whose research focuses on Indigenous policing, explained in a roundtable on rural communities, policing, and crime: "What we have learned is that in recruitment, retention, promotion, the experience of systemic discrimination, racism, and gender discrimination are

profound in the lives of many Indigenous officers. And that really urgently needs to be addressed."[160]

Sgt. Darren Bernard, a Mi'kmaw man who was the detachment commander of the RCMP's Millbrook detachment at the time of the mass casualty, reflected in his Commission interview that he had experienced racism in his working life and that there is "quiet racism everywhere."[161] He also recalled, "[T]here were a lot of racist comments along the way, like a lot."[162]

Dr. Akwasi Owusu-Bempah, a professor of sociology at the University of Toronto, explained in another forum that his research shows that Canadian "racialized officers do not feel that they are taken into the police subculture and brought into the police brotherhood. I use the term 'brotherhood' there purposely. They're overlooked for task and area assignments, and too often passed over for promotion."[163]

In one of our roundtables, Supt. Dan Morrow of RCMP H Division, who is a Cree man, explained how he and his wife, who is Métis, draw on their own experiences of racism to provide more effective policing services:

> I have almost 20 years of work in Indigenous communities and I'm status Cree, I didn't grow up on the reserve, but prior to even joining the RCMP, and my wife is Manitoba Métis, our stories are very similar, we've both experienced personal verbal and physical attacks based on the colour of our skin. And that's something you can't teach. But when you go into an isolated community, racialized community, you're able to relate to people a lot quicker and the guards come down, so you're able to establish that trust that's necessary with your client.[164]

It is notable that the 2021 report *Systemic Racism in Policing in Canada* made 42 recommendations for addressing systemic racism, most of which were directed to the RCMP.

Against this background, comments made by H Division leaders that Commr. Lucki's acknowledgement "threw us all under the bus" or made individual members feel like "they were being accused of being racism" suggest a failure on the part of these senior officers and civilian leaders to make an effort to learn about and understand the commissioner's remarks about systemic racism. Similarly, the comments reveal a reluctance to engage sincerely in the uncomfortable conversations that Commr. Lucki's statement invites.

Dr. Loftus documents that tensions between rank-and-file members and management "are likely to be compounded if reform is imposed from above without the participation and consultation of the front line – a common occurrence after scandal and formal or public critique."[165] Retired A/Commr. Bergerman said in her interview with the Commission that Commr. Lucki's statement "caused a lot of issues for members that the Commissioner wasn't sticking up for her employees overall."[166] In this instance, certain senior leaders of H Division appear to have aligned themselves with the perspective of certain rank-and-file members. Their failure to seek to understand Commr. Lucki's statement or to support this institutional acknowledgment, and national headquarters' apparent failure to provide resources to divisional leaders to help them understand and redirect internal misunderstandings about systemic racism, undermined the value of Commr. Lucki's public acknowledgment.

Mr. Bastarache, too, observed a tendency to reject nuanced discussion about the operation of racism: "Recent response to the issue of systemic racism has demonstrated that the RCMP leadership or membership either does not understand what systemic racism is, or if they do, they do not believe that it exists within their organization, or they are willfully blind."[167] Mr. Bastarache provides the following analysis of this tendency to deny the operation of structural racism and systemic gender bias:

> I am of the view that the leadership and membership of the RCMP suffer from a certain cognitive dissonance: they are well intentioned, believe themselves to be ethical, hence, systemic racism or systemic gender-based disadvantages and discrimination cannot exist in the RCMP. They rely on the "few bad apples" justification. This approach allows an organization to continue on as it is relying on the impression that simply finding these bad apples will solve the issue. They are not willing to recognize the systemic and cultural nature of sexual harassment and gender and sexual orientation–based harassment in the RCMP.
>
> The inability to acknowledge that a problem exists will inevitably render attempts to address that problem ineffective.
>
> I met several women who had achieved a senior rank, but they were sidelined – their careers derailed – when they spoke out about systemic issues of gender and race. The leadership has lived this culture and their identity is grounded on its values and beliefs. This generates defensiveness and a certain resistance to true change. And since this culture is based

> on systemic biases and structural inequalities, the race- and gender-based discrimination and disadvantages that go with it continue to be perpetuated.[168]

Mr. Bastarache concluded that the necessary cultural change could not come from inside the RCMP in its present form. Indeed, Mr. Bastarache also reviewed the RCMP's response to past reports and litigation with respect to sexual harassment of women in the RCMP. He summarized the results of his review as follows:

> Since 2007, there have been at least 15 reports, internal and external, that have highlighted workplace issues and at least in part addressed harassment, including sexual harassment.
>
> ...
>
> Past litigation, discussion in Parliament, and prior reports reveal what was known by RCMP management about harassment in their workplaces. The systemic discrimination that prevailed for years has been tolerated.[169]

Mr. Bastarache concluded that "Trying to solve problems from within has been attempted several times" without effective results.[170]

In 2007, Mr. Brown and his task force colleagues concluded:

> [T]he RCMP in its current structure is not a change-ready organization. Preparing the RCMP for change will require the engagement of members and employees at all levels plus an alignment of processes, key infrastructures, organizational culture and leadership. The implementation of change will require careful planning with the commitment and active participation by both the RCMP and the federal government.
>
> Time is also an issue. Although the change process involves many steps which must be carefully thought through and properly sequenced, the issues facing the RCMP, its members and employees must be addressed quickly.
>
> The Task Force believes that external assistance is necessary to guide and drive the change process while guiding it to timely success.[171]

Some changes have been made to the RCMP in response to both of these reports. However, the evidence before us suggests that the problems they identify persist within the organization despite those efforts.

The mandate of this Commission differs from the Brown Task Force and the Bastarache review in that it has gathered evidence about decision-making and leadership in the operational work of the RCMP. However, the cultural patterns documented by Mr. Brown and Mr. Bastarache are replicated in this context. **Efforts at positive change – such as the 2015 initiative by officers in the Atlantic Regional Council of Criminal Operations to provide clear guidance with respect to critical incident response, efforts to conduct an after-action review following the mass casualty, and the attempt to provide Emergency Response Team members with a minimal accommodation after a traumatic incident – are often defeated by institutional inertia and failures of process.** RCMP witnesses frequently expressed uncertainty about who had made (or failed to make) a particular decision, or who was responsible for a given action, even when they had been active participants in discussions about that decision or action. Mr. Brown's observation, made in 2007, that in the RCMP it is frequently safest not to make a decision that could be criticized and not to pass bad news up the chain of command continues to resonate in 2023 despite the organizational changes that have been made since that time. Like Mr. Brown and Mr. Bastarache, we believe the RCMP is incapable of addressing these problems on its own.

An organization that tolerates sexism, racism, or discrimination within its own ranks and whose leaders decline to engage sincerely in uncomfortable conversations about systemic bias is not capable of recognizing and effectively countering gender-based violence, systemic racism, or other equality-based harms through its policing. There is a strong relationship among organizational culture, the behaviour of police officers, and their capacity to recognize and constructively respond to gender-based and race-based violence. In short, understanding and countering sexism, racism, and discrimination is an operational imperative.

In the course of the Commission's work, a further controversy arose with respect to staffing decisions made by the RCMP for the Issues Management Team / H-Strong II. As we explain in Part B of this volume, this team was established to serve several functions, including studying issues of national importance arising from the mass casualty and preparing documents for disclosure to the Mass Casualty Commission. In late May 2021, media reported that the team tasked with managing

the RCMP's response to the Mass Casualty Commission included the spouses of A/Commr. Lee Bergerman and C/Supt. Janis Gray.

Conflicts of Interest in RCMP Staffing to Prepare for the Mass Casualty Commission

In December 2020, C/Supt. John Robin was appointed commander of the Issues Management Team. C/Supt. Robin is the spouse of C/Supt. Gray, and his appointment was approved by D/Commr. Brian Brennan (to whom he reported), A/Commr. Bergerman (to whom he had a "dotted" reporting line), and the RCMP's director general of executive and officer development and resourcing, Ms. Natalie Boureau.

Also appointed to the Issues Management Team was retired S/Sgt. Michael (Mike) Butcher, who is the spouse of A/Commr. Bergerman. Mr. Butcher served as assistant file coordinator, with particular responsibilities for "managing the data set" and serving as "gatekeeper of all records."[172] Mr. Butcher was hired by C/Supt. Leather at A/Commr. Bergerman's suggestion.

On May 31, 2021, National Police Federation president Brian Sauvé emailed A/Commr. Stephanie Sachsse, the RCMP professional responsibility officer, regarding "the developments in H Division with the upcoming Mass Casualty Commission and the admissions that 2 of the RCMP command team have their spouses working on that file. John Robin, married to Janis Gray and Mike Burcher [*sic*], married to the CO [commanding office]." Mr. Sauvé suggested that the RCMP "reconsider on this one."[173]

On June 2, 2021, D/Commr. Brennan requested that the Professional Ethics Office undertake a review of the matter (the "Conflict of Interest Review"). Supt. Kerry Petryshyn completed the review on June 4, 2021, concluding that there was an apparent conflict of interest with respect to the appointment of C/Supt. Robin, and an actual conflict of interest with respect to the hiring of Mr. Butcher.

With respect to C/Supt. Robin, the Conflict of Interest Review report states in part:

> Two concerns exist regarding C/Supt. Robin. The first is the potential conflict of interest with his duties and with his spouse who reports to the CO. While it can be assumed that both individuals can maintain a personal /

> professional division between their work and relationship, there still exists the potential for influence both directly from the CO to whom C/Supt. Robin's spouse reports and indirectly via his spouse who is in a subordinate relationship to the CO. The second is the apparent conflict of interest that exists and might be perceived by the public simply due to the marital relationship between C/Supt. Robin and C/Supt. Gray who reports to the CO.[174]

With respect to Mr. Butcher, Supt. Petryshyn explained the conflict of interest as follows:

> Whether the CO specifically directed C/Supt. Leather, her direct report, to hire her husband or she simply pointed it out to C/Supt. Leather that her husband was local and had the necessary skill sets, either way the reasonable person would conclude that it was implied that the CO was making it known that she thought her husband would be a good candidate to consider. In her role as the CO, she ought to have known, given the level of public attention and concern with regard to the mass shootings in Nova Scotia and her responsibility toward the policy on conflict of interest, that either scenario could be readily viewed as either an actual, apparent or potential conflict of interest. As a result, not only should she have not even "suggested" her spouse as a potential candidate, in my opinion she also should not have even approved such a proposal, if the idea had been proposed by another, given her overall responsibility for the Division budget and the oversight and direction of the activities of resources within her Division.[175]

The Conflict of Interest Review report explained that the nature of Mr. Butcher's role – namely, managing disclosure to the Commission – exacerbated the conflict of interest:

> The circumstances around his involvement with the Inquiry response team draw concern with a potential, apparent and actual conflict of interest.
>
> The fact that he is the spouse of the person who is at the focal point of the very purpose for the inquiry, and he holds a key responsibility as file coordinator on the team [redactions for Litigation Privilege] raises the possibility for the potential of a conflict of interest. It may be that he

> conducts himself with the greatest integrity but that does not eliminate the minimum possibility of unconscious bias much like how a witness in a trial can unconsciously lean their testimony more in support of whichever side called them to the stand.
>
> It must be reiterated that the focus of the Commission is to examine the response of the RCMP on April 18th, 2020, and the CO, as the head of that response, is front and centre of accusations from the public and family of the victims that the response fell far short of what was expected. The accusations also deal with the actions of the RCMP in the days, weeks and months after the event where the RCMP is being accused of not being forthright and truthful in the information it provided to the media, the public and the families of the victims about what information it had and when and what it did with that information. Essentially, the key issue appears to be a lack of trust in the RCMP, or at a minimum, skepticism and doubt.[176]

The report also identifies that the conflict of interest presents a risk to public perceptions of the integrity of the Mass Casualty Commission process:

> It also puts at risk the integrity of the Commission and raises the distinct possibility that some might question whether documents and information that could be injurious to Butcher's spouse will be, or have been withheld. There is no information to suggest Butcher's relationship to the CO of H Division has had any influence on his ability to carry out his duties in anything but a diligent and honest manner but the simple perception of that introduces a conflict of interest and casts unnecessary doubt.[177]

The report explains that "[t]he common theme in all of these matters is trust in the police."[178]

Following the Conflict of Interest Review, both C/Supt. Robin and Mr. Butcher were removed from their positions on the Issues Management Team / H-Strong II.

We agree with Supt. Petryshyn's analysis of the actual and apparent conflicts of interest raised by the appointment of C/Supt. Robin and Mr. Butcher to the Issues Management Team / H-Strong II. We also agree that the these appointments threatened public and employee trust in the RCMP, including with respect to the Commission process. The decision to appoint these employees to these roles, and

the failure to request an ethics review until after their appointments became a matter of public and union concern, provide further evidence of the unhealthy aspects of the RCMP's management culture.

MAIN FINDING

Some aspects of the RCMP's management culture impede its operational effectiveness and thwart institutional learning and accountability. Unhealthy patterns include:

- a resistance to acknowledging and taking steps to rectify errors;
- a lack of cultural resources for responding constructively to conflict and criticism;
- an aversion to being responsible for conveying bad news or for making decisions that may be criticized;
- the tendency to make derogatory characterizations of those with whom one experiences conflict; and
- a resistance to acknowledging and grappling sincerely with difficult institutional truths, including the operation of sexism and systemic racism within the RCMP.

The RCMP will not resolve these problems until it can recognize the persistence of these problems within its management culture and address the tendency to resist acknowledging that errors have been made.

We acknowledge the overwhelming body of research that shows that organizational culture cannot be changed by external directive alone. However, we stress the fundamental importance of ensuring that initiatives to render the RCMP more operationally effective, more transparent, more democratically accountable, and more committed to substantive equality are not undermined by dissension or

wilful misunderstanding among management personnel. RCMP management must address the dysfunctional cultural patterns that have been documented in past reports and that we have observed in our process. The necessary transformation will require commitment, self-reflection, and a certain amount of courage on the part of all RCMP leaders.

We acknowledge former Commr. Lucki's undertaking, made to this Commission, to champion positive change:

> Chair, you have my commitment, but more than that, you have the commitment of my senior executives, you have my commitment of my membership. I use the word "opportunity"; we have an opportunity here to make positive change, not just for the RCMP, but for Nova Scotia, but for the entire policing community. It's a responsibility that I hold near and dear to my heart, and I feel honoured to have that responsibility, and I take that responsibility extremely seriously, as does my team. And my commitment is not just to the Commission, my commitment is to the families and friends of the victims, to all the people who have worked tirelessly over the last two years to make this happen. And I agree with you, nothing is easy and only – nothing is easy, and we will – we will champion this. You have my commitment.[179]

We encourage Commr. Lucki's successor to keep this promise, and we know that those who participated in our process will be watching closely to ensure that positive change is made.

LESSON LEARNED

Efforts to reform the police can have complex results when they are filtered through the informal norms and values of police organizations. Management culture is an important determinant of the success of efforts at police reform.

Recommendation P.59

RCMP MANAGEMENT CULTURE

The Commission recommends that

(a) Within six months of the publication of this Report, the RCMP commissioner provide to the responsible minister and the Management Advisory Board, and publish on the RCMP website, a document that explains the criteria on which the RCMP presently selects, develops, recognizes, and rewards its commissioned officers and those in equivalent civilian roles. This document should include a detailed explanation of the following:

  (i) how the RCMP will change these criteria to disrupt the unhealthy aspects of the RCMP's management culture; and

  (ii) what other steps are being taken to address the unhealthy aspects of the RCMP's management culture that are identified in this Report, in the Bastarache Report, and by the Brown Task Force.

(b) Starting no later than one year after publication of this Report, the Commissioner should provide semi-annual written updates to the responsible minister and the Management Advisory Board on its progress in addressing the recommendations made in this Report. These updates should include timelines for the achievement of each milestone and should also be posted to the RCMP website.

We urge the responsible minister, the Management Advisory Board, the media, and the public to hold the RCMP accountable for making these necessary changes. The RCMP's future as a police service that has the trust of the communities it serves depends on its capacity to meet this challenge.

CHAPTER 11

The Future of Policing in Nova Scotia

CHAPTER 11 The Future of Policing in Nova Scotia

In Volume 4, Community, we explained that community safety is best conceived as an ecosystem in which police agencies play an important role, and in which the contributions of other agencies have been underacknowledged and – crucially – underfunded. We suggested that establishing an inclusive vision of community safety and a process for achieving that vision is an essential step for every community. These conversations are a precondition for thinking in more principled ways about what role the police should play in contributing to community safety.

In Chapter 9, we offered some answers to the question, "What are the police for?" In particular, we adopted Dr. Ian Loader's eight principles of policing, and suggested that they offer a basis for considering what work the police are best equipped to do, and how they should go about doing that work. In Chapter 10, we set out recommendations to bring the RCMP into alignment with Dr. Loader's principles. We identified that implementing these recommendations is necessary if the RCMP is to have a future providing democratic, rights-responsive, equality-regarding police services.

While communities are discussing inclusive models of community safety and how best to pursue them, and the RCMP is implementing change, police in Nova Scotia will continue their work. Accordingly, this chapter addresses three key topics. In the first section, we provide a brief history of policing in Nova Scotia and a description of the present state of policing services in the province. In that section, we also describe some of the key reforms that have been made to policing services in Nova Scotia since colonization. In the second section, we set out six recommendations for changes that should promptly be made to Nova Scotia policing. These changes can and should be implemented while longer-term conversations about community safety are unfolding. In the third section, we call for a structured, community-wide process to discuss and decide the future of policing services in Nova Scotia.

The History and Present Structure of Policing in Nova Scotia

Today, police services are delivered in Nova Scotia by a range of policing agencies. Community agencies also provide safety services that address gaps in policing. The RCMP holds the Provincial Police Services Agreement and supplies federal policing services in the province. Under the Provincial Police Services Agreement, a further 40 municipalities obtain policing services from the RCMP, using the Province of Nova Scotia as their representative for negotiating these services. The RCMP also holds five Municipal Police Services Agreements in Nova Scotia, under which it contracts directly with municipalities to deliver municipal policing services. In addition to RCMP police services, 10 municipal police agencies provide policing services directly to municipalities. These police services range in size from Halifax Regional Police (HRP), with 807 employees, to Annapolis Royal Police Service, with four employees.

Mi'kmaw communities in Nova Scotia have entered tripartite agreements (with Nova Scotia and Canada) or quadripartite agreements (also including the local municipality) for the provision of policing services on reserves. Eight such agreements presently exist: seven tripartite agreements with the RCMP and one quadripartite agreement with Cape Breton Regional Municipality. For approximately five years, until 2001, five Mi'kmaw communities in Cape Breton were served by the Unama'ki Tribal Police Service.

In 2020, the RCMP had 1,427 employees in Nova Scotia, including 1,003 employees under the Provincial Police Services Agreement, 45 employees provided under Municipal Police Services Agreements, and 47 employees provided under tripartite agreements with First Nations. The total number of municipal police employees in Nova Scotia in 2020 was 1,257.

Table of Nova Scotia police agencies by size

Police Agency		Number of Employees
RCMP	Provincial Contract – Provincial Policing Service Agreement	1,003
	Federal Policing	158
	Municipal Contract – Municipal Police Service Agreement	45
	First Nations – Community Tripartite Agreement	47
	Administration (Divisional, Departmental, and Regional)	174
Large municipal agencies (more than 100 employees)	Halifax Regional Police	741
	Cape Breton Regional Police Service	230
Medium municipal agencies (more than 24 employees)	Truro Police Service	51
	New Glasgow Regional Police Service	42
	Bridgewater Police Service	37
	Amherst Police Department	30
Small municipal agencies (fewer than 25 employees)	Kentville Police Service	21
	Stellarton Police Service	19
	Westville Police Service	11
	Annapolis Police Service	4

Source | Commissioned report prepared by Barry MacKnight, "The Structure of Policing in Nova Scotia in April 2020," Mass Casualty Commission (November 2021) at 24: COMM0040450.

The diversity of communities served by Nova Scotia police is reflected in this description of the communities served by the Digby RCMP detachment: "The Digby RCMP detachment polices approximately 20 communities in Digby County. This rural area of about 18,000 residents is a microcosm of Canada's diversity: there's a Mi'kma[w] First Nations community called Bear River [L'sitkuk], two islands with isolated fishing villages, and three African Nova-Scotian communities with historic roots dating back to the 18th century."[1]

Governance and the Provincial Police Services Agreement

In Volume 1, Context and Purpose, we supplied an overview of the roles, responsibilities, and resources of the Nova Scotia Department of Justice, municipalities, the RCMP, municipal police services, and the Serious Incident Response Team (SiRT) with respect to policing services in Nova Scotia. The Nova Scotia *Police Act*, SNS 2004, c 31 contains a number of important provisions with respect to these roles and responsibilities. Under section 5(1) of the Act, the Nova Scotia minister of justice must "ensure that an adequate and effective level of policing is maintained throughout the Province."[2] Section 5(2) says that the minister "shall promote the preservation of peace, the prevention of crime, the efficiency of police services and the improvement of police relationships with communities within the Province."[3] Section 5(3) allows the minister to issue directives, standard operating procedures, and administrative procedures to police departments or to SiRT, or to require these bodies, a police board, or advisory board to develop such documents. Section 6 assigns a number of other powers to the minister.

Pursuant to section 27 of the Act, the RCMP is the provincial police service for Nova Scotia. Under section 28(1) of the Act, the provincial police is "under the general control and supervision of the Minister."[4] However, because the RCMP is a federal agency, the minister's capacity to direct the RCMP is limited. The Provincial Police Services Agreement between Nova Scotia and Canada provides that:

> The Parties recognize that:
>
> (i) the Province has the constitutional jurisdiction over the administration of justice which includes the responsibility for policing;
>
> (ii) the RCMP is a federal entity and matters relating to the control, management, and administration of the RCMP are within exclusive federal jurisdiction; and
>
> (iii) the Commissioner of the Royal Canadian Mounted Police, under the direction of the Federal Minister, has the control and management of the RCMP and all matters connected therewith.[5]

And that:

> The RCMP acting under this Agreement as the Provincial Police Service aids the Province in the administration of justice by implementing the provincial policing objectives, priorities and goals as determined by the Provincial Minister.[6]

Accordingly, Nova Scotia has the capacity to set policing priorities. However, subject to direction provided by the federal minister of public safety, the RCMP commissioner retains the control and management of the RCMP "and all matters connected" with that responsibility. In clause 6.2, the Provincial Police Services Agreement specifies that the administration and internal management of the RCMP and the determination and application of police standards and procedures "will remain under the control of Canada."[7] There is some room given for negotiation of standards through a process by which the RCMP commissioner commits to harmonizing RCMP standards with provincial police standards "unless the Commissioner is of the opinion that to do so would … negatively affect the RCMP's ability to deliver effective or efficient police services, or negatively affect public or officer safety."[8] Likewise, the agreement commits the commanding officer to "implement the objectives, priorities, and goals" determined by the provincial minister "to the extent practicable."[9] However, former Nova Scotia minister of justice Mark Furey told the Commission that in his time as minister, he was not confident that the RCMP was implementing Nova Scotia's priorities:

> Bi-annual meetings took place in which H Division leadership provided briefings and updates, delivered power point presentations by/with subject matter individuals to me in my role as Minister of Justice. I always found the feedback provided by H Division to be ambiguous and evasive, and I left these meetings without any real confidence objectives were being achieved.[10]

The Provincial Police Services Agreement commits Canada and Nova Scotia to work together, including with respect to "substantive decisions affecting the quality and cost" of the RCMP's policing services.[11]

The *Police Act* establishes a Nova Scotia police complaints commissioner, who may receive complaints from members of the public or from police officers about the conduct of municipal police officers. It also establishes a Police Review Board, which conducts investigations and holds hearings about matters including public complaints referred by the police complaints commissioner and matters referred by the minister or a municipal council or police board. As we explained in the

previous chapter, public complaints about the RCMP are handled by the Civilian Review and Complaints Commission for the RCMP. Most *Code of Conduct* investigations into the conduct of RCMP members are, pursuant to the *Royal Canadian Mounted Police Act*, handled internally; some are subject to a conduct hearing, which is public and leads to a public decision. In addition to the police complaints commissioner and Police Review Board, the third key accountability process in Nova Scotia policing is supplied by the Serious Incident Response Team, which has the jurisdiction to investigate serious complaints including matters that involve death, serious injury, sexual assault, and intimate partner and family violence against all Nova Scotia police officers, including RCMP members who are in Nova Scotia. Members of SiRT, including the director, are peace officers under the Nova Scotia *Police Act*, and have all the powers and authorities accorded to other police officers. Chief officers of police services in Nova Scotia have a statutory duty to notify SiRT of incidents that may engage its jurisdiction. SiRT is obliged to report to the minister and the agency that employs the subject police officer, and must also publish a public summary of its investigation. In Part B of this volume, we discussed SiRT's role in the aftermath of the mass casualty.

This complex patchwork of oversight and complaint mechanisms has its origins in a 1978 decision of the Supreme Court of Canada, which held in relation to the RCMP:

> Parliament's authority for the establishment of this force and its management as part of the Government of Canada is unquestioned. It is therefore clear that no provincial authority may intrude into its management. While members of the force enjoy no immunity from the criminal law and the jurisdiction of the proper provincial authorities to investigate and prosecute criminal acts committed by any of them as by any other person, these authorities cannot, under the guise of carrying on such investigations, pursue the inquiry into the administration and management of the force.[12]

In the subsequent decision of *Attorney General of Alberta et al. v Putnam et al.* (1981), a majority of the Supreme Court of Canada held that this prohibition on provincial interference with federal control of the RCMP extends to the management of public complaints about member conduct. Justice Brian Dickson (as he then was) issued a strong dissent in the *Putnam* case, observing that "great areas of the policing services across Canada at the provincial and local level are carried out by a federal 'para-military' force … constitutionally accountable, according to the federal position in this appeal, only to Ottawa."[13]

Changes in the Structure of Police Services

The delivery of police services in Nova Scotia today is a complex patchwork of municipal, provincial, federal, and Indigenous jurisdiction, funding, and service delivery models. The structure of police services in Nova Scotia has changed significantly since colonization, and it has been the subject of considerable law reform efforts in recent years.

The number of municipal police services in Nova Scotia and the places to which police services are delivered by the RCMP or municipal police services has varied over time.

In 2003, academics Anthony Thomson, Don Clairmont, and Lynda Clairmont, working with the Atlantic Institute of Criminology, edited a study of small-town and rural policing in Nova Scotia, in which they documented the impact of changes in police service delivery in the Annapolis Valley. This collection begins with a striking vignette:

> When we accompanied three small town Police Chiefs on a recruiting mission to the Atlantic Police Academy in 1992, the future of small town policing appeared unproblematic. Ten years later, two of these former Chiefs had served time in jail, for mismanaging funds and sexual exploitation, and the third was working as an RCMP Constable on highway patrol. It is tempting to claim these striking events as an epitaph for the rapid erosion of small town policing in the Valley. As always, separating reality from myth is much more complex.[14]

The authors explain that the 15 years before 2003 was a time of organizational change in policing, "brought about by the forces of modernization and regionalization."[15] They observed two paths leading Nova Scotia away from the model of small municipal police forces and toward either "the regionalization of small-town municipal police in propitious geographical areas, such as north-eastern Cape Breton and industrial Pictou County, or the absorption of existing small town departments by the RCMP as a regional force."[16] Between 1987 and 2002, 26 municipal police departments in Nova Scotia were reduced to 12.[17] Since Dr. Thomson, Dr. Clairmont, and Dr. Clairmont published their study, the number of municipal police services has remained far more stable.

The changes that Thomson, Clairmont, and Clairmont documented were partly driven by financial considerations. Until 1981, RCMP policing was heavily subsidized by the federal government, with 50 percent of the cost of policing billed to municipalities. Between 1981 and 1991, the proportion of costs billed to municipalities was steadily increased, until municipalities paid 70 percent of the total cost. In 2003, these authors reported that "[c]urrently, the factors pushing or pulling municipal policing towards the RCMP are complex." Twenty years later, the financial picture remains complex. For rural areas, municipalities of fewer than 5,000 residents, and some grandfathered municipalities, the proportion of costs paid by the federal government is still 30 percent. Municipalities with greater than 5,000 residents who do not have grandfathered status now pay 90 percent of the cost of RCMP policing services.

As the text box below shows, the structure of police services in Nova Scotia has been a focus of law reform efforts, and has changed many times since colonization.

The Changing Structure of Police Services in Nova Scotia

Peace and Friendship treaties were entered between the British and Mi'kmaq between 1725 and 1779. These treaties continue to govern important aspects of the relationship between Mi'kmaq and other Canadians today, including the application and enforcement of criminal law and regulations.

Some forms of policing were present in Nova Scotia as early as 1749, with assigned constables responsible for the ports. In Halifax, night patrols were established in 1799 and later merged with the day watch to form the Halifax Police in 1864. Many Nova Scotian towns and municipalities began to establish police services between the 1860s and 1890s. Federal government agents enforced colonial laws on Mi'kmaw reserves, including the forcible relocation of Indigenous communities and the enforcement of laws such as those pertaining to residential schooling.

Before 1930, emergency provincial police units were on occasion sworn in under the *Constables Act* to break coal strikes in Cape Breton. Private "company police" were also engaged by corporations to protect corporate property and monitor employees. Temperance police were employed from 1910 to 1929 to enforce laws associated with the prohibition of alcohol.

The first provincial police service, the Nova Scotia Police, was established in 1930 after a plebiscite. Initially, the force consisted of approximately 100 officers, most of whom were formerly temperance inspectors. This service did not replace municipal police services, but provided policing services in rural areas that lacked their own service.

The Nova Scotia Police lasted only two years before the Province of Nova Scotia entered a contract with the RCMP for the provision of provincial policing services. The RCMP's provincial services were federally subsidized, initially at a rate of 50 percent, and the service absorbed personnel from the Nova Scotia Police. This approach meant that initially the RCMP was a "distant authority … but they were not always from away."[18]

In the 1940s, the federal government enforced further relocations on Mi'kmaw communities, forcibly relocating 19 existing communities into two locations: Eskasoni and Sipenkne'katik. By the 1960s, the federal government began to withdraw from providing policing services in Indigenous communities. Band constables were appointed in some Mi'kmaw communities to serve alongside city police and RCMP.

Between the 1960s and late 1990s, many small municipal police agencies in Nova Scotia were either amalgamated into larger regional police services or absorbed into the RCMP. These changes were driven by financial considerations (including the subsidy offered by the federal government). There was also a belief, toward the end of this period, that it was necessary for police services to professionalize. Ideas about professionalization through the establishment of larger, more systematized police agencies "emerged in response to perceived deficiencies in the small town model such as excessive parochialism and discriminatory enforcement."[19]

In 1989, the Royal Commission on the Donald Marshall, Jr., Prosecution issued its report along with an indictment of racism in policing and the justice system in Nova Scotia. The commission found wrongdoing across many agencies of the Nova Scotia justice system, including on the part of the Sydney Police and RCMP. The commission arose from the wrongful conviction of Mi'kmaw youth Donald Marshall Jr. in 1971. Sydney Police charged Mr. Marshall (then 17 years old) with the murder of Black youth Sandy Seale. Despite being innocent, Mr. Marshall was convicted. In 1983, the Nova Scotia Court of Appeal acquitted Mr. Marshall, but the court blamed him for his wrongful conviction, maintaining that he was "the author of his own misfortune." The commission concluded that Mr. Marshall's

wrongful conviction was "due, in part at least, to the fact that Donald Marshall, Jr. is a Native."[20] Of 82 recommendations made in the report, 37 related to policing. Volume Two of the Royal Commission's final report is dedicated to "Public Policing in Nova Scotia."

In 1992, the Province of Nova Scotia introduced service exchange, a comprehensive cost-sharing agreement with Nova Scotia municipalities. Under service exchange, municipalities and counties became responsible for paying for provincial policing services.

In the mid 1990s, the Halifax, Dartmouth, and Bedford Police Services were amalgamated into the Halifax Regional Police with the creation of the Halifax Regional Municipality (HRM), and municipal police services in industrial Cape Breton became the Cape Breton Regional Police with the creation of the Cape Breton Regional Municipality.

In 1998, a Police Act Review Committee was formed with a mandate to study the Nova Scotia *Police Act* and make recommendations for changes. The work of the committee took several years, and led to a new *Police Act* being passed in 2004, with an increased emphasis on police governance.

In 2007, an internal working group of the Nova Scotia Department of Justice evaluated the adequacy and effectiveness of policing services delivery in Nova Scotia, to prepare "for a recommendation for a provincial police services agreement for 2012."[21] The *Policing Solutions 2012 Report* evaluated "current policing service delivery in Nova Scotia, according to the criteria of: operational effectiveness; accountability; administrative feasibility; cost effectiveness; and equity."[22] The report identified gaps and blurred lines in accountability for RCMP and municipal policing. It concluded that differences in the command and accountability structures of RCMP and municipal police agencies impede "both administrative and operational effectiveness."[23]

In 2012, the Province of Nova Scotia entered a new Provincial Police Services Agreement with the RCMP, for a term of 20 years.

Police and Community Safety Services in Mi'kmaw Communities

Changes in the delivery of police services have also been significant for Mi'kmaw communities in Nova Scotia. For example, Membertou First Nation on Cape Breton Island now receives policing services from Cape Breton Regional Police Service. Eskasoni First Nation, also on Cape Breton Island, obtains policing services from the RCMP. While it was active, the Unama'ki Tribal Police Service policed both of these communities. From 1971 until 1995, Membertou received police services from Sydney Police, which amalgamated with other Cape Breton municipal police agencies in 1995 to become Cape Breton Regional Police.

Similarly, in 1973, the Truro Police Service (TPS) jurisdiction was extended to Millbrook First Nation. In 1995, Millbrook First Nation entered a tripartite agreement with the RCMP for the provision of policing services, and that contract remains in place today. Police services provided by the RCMP at Millbrook are supplemented by a public safety program delivered by Millbrook First Nation in which community workers serve as liaison and cultural navigators between the police and community members. These community workers are first responders to 75 percent to 80 percent of all calls from the Millbrook First Nation. In a consultative conference convened by the Commission with Mi'kmaw community members, Luke Markie, a community safety worker from Millbrook, explained why this project is the first port of call for Millbrook community members:

> [B]ecause we are from the community. We are within the community. We know everybody … a lot of our elders so they're more likely to call someone like me that they do know, or one of our workers that's like a nephew, or an uncle, or cousin, or whatever, and they'll be like, "Hey, like, there's possibly this situation going on," and then we will alert the RCMP after that because we're not necessarily hands on.[24]

Historically, the federal government was responsible for the provision of policing services on First Nation reserves. In a paper prepared for Public Safety Canada, Dr. Jane McMillan, chair of the Department of Anthropology at St. Francis Xavier University, explains that until the 1970s, policing on Mi'kmaw reserves in Nova Scotia was provided by RCMP members. In the late 1960s, band constables were introduced after the RCMP announced that it was withdrawing from policing some First Nations communities. Band constables were Indigenous police officers whose

role supplemented, but did not replace, police in the local area. Band constables were "wildly under resourced. Officers had to use their own cars, they had no office space, no desks, and they were unarmed."[25] After a turbulent period between the late 1960s and early 1990s, the federal government and the province settled a First Nations Policing Policy in which the federal government pays 52 percent of a First Nation's policing costs while the province contributes 48 percent. However, Dr. McMillan explains that the "First Nations Policing Program is classified as a discretionary program which permits its underfunding in comparison to municipal and provincial police forces."[26]

Policing for Community:
The Example of the Unama'ki Tribal Police Service

The Unama'ki Tribal Police Service operated for approximately five years, from 1995 to 2001. A collaboration among Mi'kmaw chiefs and the provincial and federal governments, the Unama'ki Tribal Police Service was regarded by Mi'kmaw community members as "a very exciting welcomed opportunity for people to return to policing in a style and a manner that really reflected community, community needs, and community dispute management."[27] The success of the program was indicated by the fact that "the call rate to police for help, for services went through the roof."[28] But the service was underfunded and relationships with other police services were not formalized, and the Unama'ki Tribal Police Service was unable to meet community demand. At the end of the five-year funding agreement, the service folded.

The demise of the Unama'ki Tribal Police Service can be attributed to several factors, particularly underfunding. In a roundtable on the structure of policing in Nova Scotia, we heard from Professor Heidi Marshall, a member of Membertou First Nation and founder of the Jane Paul Indigenous Resource Centre on Cape Breton Island, who participated in intergovernmental negotiations regarding the Unama'ki Tribal Police Service. Professor Marshall reflected:

> [O]ne thing that always stuck in my head and still does today is that the policing service at the airport had more funding than the tribal police. So that, to me, was an indication of how much effort and how much resources and how much even care that, you know, that the government of Canada and the province and how much they invested in our communities, you know. And to me, we faced

> obstacles right at the beginning, underfunding, overworked staff, jurisdictional issues …
>
> [W]e're still trying to improve community safety and public safety, but we still have all these issues and obstacles that are put in our way.[29]

Our consultative conference with Indigenous community members included Clifford Paul of Membertou First Nation, who worked for the Unama'ki Tribal Police Service from 1995 to 2000. Mr. Paul is now a member of the RCMP H Division Mi'kmaq and Indigenous Advisory Committee and an employee of the Assembly of Nova Scotia Mi'kmaw Chiefs. He recalled of the Unama'ki Tribal Police:

> We were so under-funded. And I'm not going to lie to you. My pay, doing criminal records management and police dispatching, my pay was $19,600. It was the lowest ever, I ever earned in my life, working for the Tribal Police.
>
> And Membertou Welfare had to supplement my income so that I could work …
>
> But man, we were sad to see it go down because that was Police Chief John Leonard Tony's dream to set up a Tribal Police force. And I wish it was the dream of the Department of Justice as well. Maybe they would still be policing their communities. Maybe the Mi'kmaq language would be brought into homes where you have to de-escalate situations and a simple word like "Meskey" or "wele'g," settle down – you know what I mean? That goes a long way.[30]

Professor Marshall identified that the gap in culturally competent community safety services that was left when the Unama'ki Tribal Police Service closed down is now being filled by other Indigenous services and community members, often on a volunteer basis. The Jane Paul Indigenous Resource Centre provides an example of this dynamic. This centre is funded by the Nova Scotia Native Women's Association and by donations. It is dedicated to safeguarding Indigenous women's safety, and its work adapts to address gaps in other systems and to compensate for a lack of community trust in other community safety providers: "[O]ur women at the centre lost faith in all the systems, not only on the reserve, but off the reserve. They have no faith in the leadership, in policing,

in Mi'kmaq legal support. They don't trust any of those systems."[31] The centre provides a range of services, including housing support, counselling, a child and youth space, crisis navigation, and food security services, without stable core funding. In addition, Professor Marshall explained, "there are times even when I'm not at the centre working, I still drive the back alleys in Sydney to make sure our women are safe."[32] She also observed, "we still accompany people to court, even though we don't have a court worker program … We get calls at three in the morning. We get calls of women being stuck somewhere in New Waterford at risk, you know."[33]

The demise of the Unama'ki Tribal Police Service and creation of the Jane Paul Indigenous Resource Centre illustrate that community safety services can be provided in many ways. Where there is a gap in policing services, community members and not-for-profit agencies will do their best to fill that gap**. Indeed, in many instances, as with the Jane Paul centre, these community members and agencies may be more expert, more culturally competent, and better able to gain the trust of marginalized community members than provincial or municipal police services. However, unlike provincial and municipal police services, many of these agencies operate without stable, core funding and without any certainty that they will be able to continue offering their services for the long term.** As Professor Marshall explained, securing community safety for Indigenous women is "not just an Indigenous responsibility, it's not just a Mi'kmaq responsibility, you know. Like, everyone has a vested interest … the Cape Breton Regional Municipality does, the police do, we all do."

LESSON LEARNED

Community safety and well-being must be community-specific. Layers of harms caused by colonialism and racism mean that a policing response to endemic issues that arise from those harms in First Nations, Inuit, and Métis communities must be developed through a sincere community engagement process that respects Indigenous laws and provides equitable funding for Indigenous community safety and well-being.

As the example of the rise and fall of the Unama'ki Tribal Police Service demonstrates, other community safety providers expand and contract as necessary when gaps arise in the effectiveness of policing services or when community trust in policing services is not present. In the next section of this chapter, we identify six matters on which reform to police services is both pressing and feasible.

Immediate Reforms to Police Services in Nova Scotia

In this section, we identify six areas in which changes can rapidly be made to police services in Nova Scotia that will have a significant positive effect on overall community safety and the effectiveness of policing services. These six areas are:

1. Establish a comprehensive model for mental health services across the province, including crisis mental health care, in order to shift the practice of using police as the sole first responders to mental health calls.
2. Revitalize police boards by funding them to function effectively and provide standard training to all relevant personnel about their role.
3. Establish a provincial policing standard that requires police services to publish their policies online.
4. Formalize arrangements for integrated police units and the provision of specialized policing services.
5. Study the feasibility of adopting a unified public safety answering point (PSAP) for Nova Scotia.
6. Address existing conflict among police leaders in Nova Scotia and establish conflict resolution mechanisms for the future.

The justification for addressing each of these areas is explained below.

Establish a Comprehensive Model for Mental Health Services

A 2020 review of RCMP policing services in Colchester County reported that in 2019 RCMP members spent 2,789 hours responding to mental health calls in the county. This represented 10 percent of the total available time of uniformed first responders in Colchester Country,[34] at a cost of approximately $273,500 (based on the $151,922 per member cost of RCMP policing). The total number of uniformed first responders assigned to Colchester County in 2019 was 18. This study indicates that much of the RCMP's time spent responding to mental health crises included repeated calls to the same person. Similarly, a review of RCMP policing in Cumberland County in 2019 reports that RCMP members in that county spent 2,477 hours responding to mental health calls.

Among those who contributed to our process it was universally agreed that police are not best trained or equipped to act as first responders to those who experience a mental health crisis, and that serving this function takes police away from performing other functions for which they are better suited. In Volume 4, Community, we described the evidence we heard from Dr. Jamie Livingston, associate professor of criminology at Saint Mary's University, about the scarcity of mental health services outside the urban core of Halifax and Dartmouth. While the 211 phone service provides a useful navigation tool, it is not a substitute for the provision of comprehensive mental health services, including crisis services. There is also a 24-hour Provincial Mental Health and Addictions Crisis Line at 1-888-429-8167, but we heard that comprehensive services are greatly needed.

The Province of Nova Scotia is the primary funding agency for health services, including mental health services. Municipalities bear the primary cost of policing. The federal government subsidizes both of these services, by different means.

LESSON LEARNED

In the absence of comprehensive mental health care services, a significant amount of police time is spent providing crisis mental health responses to Nova Scotians. Police are not well placed to provide these services. Wherever possible, mental health crisis response should be reallocated to trained mental health care providers, and these providers should be adequately funded to perform this role.

Recommendation P.60

PROVIDING MENTAL HEALTH CARE TO NOVA SCOTIANS

The Commission recommends that

(a) The Province of Nova Scotia should establish a comprehensive and adequately funded model of mental health care service provision for urban and rural Nova Scotians. This model should include first response to those in mental health crisis and continuing community support services to prevent mental health crises from arising or recurring.

(b) The federal government should subsidize the cost of these services at a minimum proportion equal to the proportion to which it subsidizes RCMP policing services.

IMPLEMENTATION POINTS

- We do not make a recommendation about the specific model of mental health care to be adopted, but encourage the provincial government to consult and engage with community stakeholders in choosing the appropriate model, and to make evidence-based decisions that are informed by a diverse representation of community members.
- Regardless of the model chosen, these decisions should prioritize dignity and care within a mental health care framework over a criminal justice response.

(c) A certified mental health specialist should be embedded in the 911 public safety answering point locations across the province and available on call 24/7 to assist with assessing and triaging mental health calls.

IMPLEMENTATION POINTS

- This specialist may both ensure community members are connected with the appropriate non-police allied community safety agency and provide guidance to police responders when they must respond in person.
- This resource is especially important in rural areas where mental health teams may not be an available resource on the ground in a reasonable response time period.

- The comprehensive model should encompass consideration of how 911 standard operating procedures should be updated to reflect that mental health service providers are most often the more appropriate first responders to mental health calls, but that police will be dispatched to these calls when the mental health service provider indicates that this is necessary.

Revitalize Police Boards

The Nova Scotia *Police Act* makes robust provision for civilian oversight of municipal police agencies via civilian police boards, and for civilian participation in RCMP policing services via police advisory boards. Due to the constraints imposed by the RCMP's status as a federal agency (discussed above and in Chapter 10), it is not possible for Nova Scotia to establish civilian oversight boards in municipalities where policing services are delivered by the RCMP. For this reason, the *Police Act* provides for police advisory boards in these municipalities. We heard that in many instances these governance and advisory boards are not serving their statutory role. In a roundtable on the structure of policing in Nova Scotia, Harry Critchley, vice-chair of the Halifax Board of Police Commissioners, advised us that 18 of 30 provincial appointments to Nova Scotia police advisory boards were unfilled as of September 2022. We also heard that Colchester County's police advisory board for the RCMP had not met between February 2019 and March 2021. Section 63 of the *Police Act* requires police advisory boards to meet "at least every three months."

The effectiveness of police boards is also impeded by underfunding: Mr. Critchley explained that the Halifax Board of Police Commissioners, which also serves as the RCMP police advisory board for Halifax Regional Municipality, received less than $14,000 in funding in 2021. This underfunding renders the police board dependent on the police service or municipality for the provision of administrative, legal, and research services. This is an untenable position for an independent governance body. As the coalition comprising the East Coast Prison Justice Society and the BC Civil Liberties Association submitted to us, effective accountability "can only be achieved if existing oversight bodies, such as municipal police boards and review agencies, are funded to function, not to fail."[35]

For municipal police services, police boards serve the oversight and accountability functions that are supplied by the responsible minister and management advisory board for the RCMP (see Chapter 10 of this volume.) Under the Nova Scotia *Police Act*, police boards have the same responsibilities to inform themselves about the operations of municipal police agencies and to issue directions, including directions about the policy of operations. In turn, police chiefs must keep police boards up to date about operations and facilitate board access to information that is necessary to allow police boards to perform their governance role.

The role and responsibilities of municipal police boards and municipal police chiefs were discussed in detail by the Honourable John Morden in his *Independent Civilian Review into Matters Relating to the G20 Summit* (2012). The Morden Report considered, among other matters, the police response to the G20 Summit in Toronto in 2010 and the role of the Toronto Police Services Board in providing oversight. The role and responsibilities of police boards and their relationships with the police chief were also discussed by the Honourable Gloria Epstein in her 2021 report *Missing and Missed: Report of the Independent Civilian Review into Missing Persons Investigations*, which considered the Toronto Police Service investigation of the serial murders of Two-Spirit, lesbian, gay, bisexual, transgender, queer, intersex and additional sexually and gender diverse (2SLGBTQI+) people in Toronto, many of whom were racialized. As she explains:

> I cannot overemphasize the importance of effective civilian oversight of the police. It promotes public respect for the police through a model that involves both governance and accountability. It can also serve as a means to ensure that special attention is given to the oversight of policing as it affects communities with a troubled relationship with the police, including racialized, LGBTQ2S+, Indigenous, homeless or underhoused, and others identified in this Report.
>
> A police services board is an essential feature of responsive and democratically accountable policing. However, a board cannot fulfill its statutory oversight responsibilities if it is not informed about "critical points," a phrase introduced by Judge Morden in his 2012 report on policing matters relating to the G20 summit.[36]

A "critical point" was defined in the Morden Report as "a policing operation, event, or organizationally-significant issue for which advance planning and approval at the Toronto Police Service's command level is required."[37]

In 2018, Senator Murray Sinclair prepared a report that conveyed the outcome of his investigation into the Thunder Bay Police Services Board's oversight of police services following a series of deaths and race-based violence against Indigenous people in that city. Observing that "Police services boards need to be cognizant and capable of carrying out all of their statutory responsibilities,"[38] Senator Sinclair concluded that the Thunder Bay Police Services Board had failed to discharge its responsibilities in numerous ways, including the following:

> - The Board did not demonstrate meaningful engagement in its own strategic or operational planning, relying for the most part on input from the Chief of Police and staff. There are no Board-developed, Board-driven planning policies or formal instruments to support long-term strategic or annual operational planning in place.
> - The Board did not demonstrate meaningful engagement in the development of governance and oversight policies. …
> - The Board has made no apparent effort to make its policies, plans and activities visible and transparent to the public at large or to the First Nation community.[39]

Some of these problems have also been documented with respect to the Halifax Regional Police Board of Commissioners.[40]

Police advisory boards play a different role from that of police boards, due to the federal structure of the RCMP. Nonetheless, they provide an important representative role for communities served by the RCMP, including the communities listed by the Honourable Gloria Epstein in the quotation above. For example, police advisory boards are responsible for determining "priorities, objectives and goals respecting police services in the community,"[41] ensuring "that police services are delivered in a manner consistent with community values, needs and expectations,"[42] and acting "as a conduit between the community and the police department."[43] They may also "recommend policies, administrative and organizational direction for the effective management of the police department."[44]

LESSON LEARNED

Effective police governance is vital to democratic policing. All participants in police governance, including board members, police leaders, and government officials, should be properly trained and aware of the role and responsibilities of governing boards.

Recommendation P.61

POLICE GOVERNANCE IN NOVA SCOTIA

The Commission recommends that

(a) The provincial Department of Justice design and provide mandatory standard training in police governance.

IMPLEMENTATION POINTS

This training should be mandatory for:

- every municipal police chief, H Division RCMP commanding officer, and detachment commander;
- provincial and municipal civil servants whose work includes the administration of police; and
- police board members and police advisory board members.

This training should:

- address the governance, oversight, and democratic accountability functions of police boards and police advisory boards;
- incorporate the eight principles of policing;
- address findings, lessons learned, and recommendations set out in this report, the Marshall Report, the Ipperwash Report, the Morden Report, the Thunder Bay Police Services Report, the Epstein Report, the Wortley Report, and the Public Order Emergency Commission Report; and

- explain the respective roles and responsibilities of board members, police leaders, and civil servants.

(b) The Nova Scotia Department of Justice should prepare a police board manual and police advisory board manual.

IMPLEMENTATION POINTS

This manual should:

- be published on the Nova Scotia Department of Justice website;
- address the governance, oversight, and democratic accountability functions of police boards and police advisory boards; and
- set out the roles and responsibilities of board members, police leaders, and civil servants.

(c) Municipalities should provide adequate funding to police boards to permit them to conduct independent research, seek legal advice, maintain records, and otherwise discharge their governance role.

(d) Municipalities and the Province of Nova Scotia should ensure that police boards and police advisory boards are fully staffed and performing their governance function.

IMPLEMENTATION POINTS

- All seats on police boards and police advisory boards should be filled through robust recruitment initiatives for qualified and diverse candidates able to make the necessary time commitment;
- municipalities and the province should ensure that boards are meeting at least every three months, in accordance with the *Police Act*; and
- where a board is not meeting, or a board member is not attending meetings, that failure must be addressed in no more than the span of two meetings.

(e) The Province of Nova Scotia should support police boards and police advisory boards to establish an independent website and public contact information to facilitate direct communication with the communities they represent and to facilitate sharing best practices with other police boards.

IMPLEMENTATION POINTS

- This website should host board governance policies, procedures, written directions to chief officers, and records of key decisions taken by the board; and
- where written directions or records of key decisions cannot be made public due to operational relevance or for other reasons, a summary of the nature of the direction must be posted as an interim measure, and the direction or decision itself should be posted if and when the reason for withholding that information lapses.

(f) Police boards and police advisory boards should hold their meetings in a place customarily open to the public. Advance notice of the time, place, agenda, and expected speakers should be posted on the board website.

(g) Police board members and police advisory board members should be proactive in establishing relationships with other community safety providers and with members of communities that have historically been underserved and overpoliced.

(h) Municipalities and the Province of Nova Scotia should ensure that police board members and police advisory board members are fairly compensated for their work if they are not serving as part of another paid role (e.g., as a municipal employee). Lack of compensation is a barrier to the participation of many community members whose voices should be represented in police governance.

Require Police Services to Make Policies Public

Throughout our process, we heard that community members, and even governance bodies, found it difficult to know what policies govern police operations and interactions with community members in Nova Scotia. While the existing provincial policing standards require Nova Scotia police to have policies in place on matters such as recruitment, patrol, and communications, there is no requirement that such policies be public. Indeed, we heard that secrecy about police policies

prevails even when there is no apparent reason for withholding such information. In a roundtable on the structure of policing in Nova Scotia, Emma Arnold, representative of the Elizabeth Fry Society of Mainland Nova Scotia, explained the relationship between transparency about police policies, and police accountability:

> [W]e tried to request a policy about Victim Services intake procedures, and were told that we could not have it because it – there was reason to expect it would harm law enforcement, and there's no way to hold them accountable to explain why that is …
>
> So to not be able to access the policies means we don't know what we can hold them accountable for, and there's no way for us to put a gendered lens or a racialized lens or intersectional lens on any of the policies to see if they will actually benefit the community, and if they are the best they could be, or if they need changes and need restructuring and have that input from community members and community organizations to ensure that the policies are the best they can be. But right now, there's no way for us to analyze these, to review them, and even for citizens to know what their rights are, as provided by the policies.[45]

Ms. Arnold related that in one instance, her organization had represented a client in a complaint against the RCMP, and the informal resolution agreed to by the RCMP and the client had been that a particular policy would be changed. Ms. Arnold explained what happened after some time had passed: "After they … said the policies are amended, she asked to see them, to see the amendments to make sure that the informal resolution was completed. But, again, they denied her access to see the amended policies."[46] As Dr. Jane McMillan observed, "I was astonished that one can't even access a policy about victim services intake. That, to me, is an absurdity, that must be addressed immediately."[47]

Defunding the Police: Defining the Way Forward for HRM – the 2022 report of the Board of the Police Commissioner's Subcommittee in Halifax Regional Municipality – explained that:

> It is important for the public to have access to the policies, procedures, and guidelines governing their police forces. These materials set out how the police interpret their responsibilities and legal authorities, and can be extremely helpful to the public in determining what to expect from police

> in various contexts. They also provide a clearer picture of how officers are expected to act on a day-to-day basis.[48]

The report relates that, in July 2020, a member of the Halifax Board of Police Commissioners introduced a motion to direct the Halifax Regional Police chief to publish HRP policies on the police service's website. Chief Daniel (Dan) Kinsella declined to do so, explaining that "many of the HRP's policies were so out of date that the entire 1,700 page manual needed an 'overhaul.'"[49] The board accepted this explanation, and the motion was not passed. As the report authors observe, the board's acquiescence "effectively defer[red] the release of the policies indefinitely."[50] The report recommended that the board "direct the HRP to immediately make their policies and procedures publicly available online, as well as any standing orders or other directives that have superseded policies that are out of date. The Police Board should make the same recommendation to the RCMP."[51] It also recommended that: "Where policies and procedures are deemed to be confidential, the Police Board must ensure that the HRP or RCMP provide a publicly available explanation for each exempted section. These explanations must comply with the exemptions from disclosure provisions under section 475 of the Municipal Government Act, SNS 1998, c 18."[52]

Other police services in Canada, including the Vancouver Police Department and the Toronto Police Service, have made their policies public, with appropriate provision being made for confidential information.

Recommendation P.62

PUBLISH POLICE POLICIES

The Commission recommends that

(a) The Nova Scotia Minister of Justice should issue a policing standard that requires police agencies that provide police services in Nova Scotia to publish – online and in an accessible form and location – policies and standard operating procedures that govern the interaction of police with the public, the manner in which policing services are provided to the public, and public communications.

(b) This standard should require that, where a policy or procedure or a portion of a policy or procedure is deemed confidential, the police service must provide a public description of each exempted section and the reason why it has been deemed confidential.

(c) The federal minister of public safety should issue a written directive to the commissioner of the RCMP, directing compliance with this provincial standard.

Formalize Arrangements for Integration and the Provision of Specialized Services

We heard a great deal of evidence from Nova Scotia police leaders, including municipal chiefs and RCMP H Division leaders, and from provincial officials about recent changes in the provincial and RCMP approach to tracking municipal police agencies' use of specialized policing services supplied by the RCMP. Witnesses provided differing accounts of when and why these changes occurred; however, all agreed that municipal police agencies are now being asked to complete forms that record their use of these services, and that this was not previously the case. Some municipal chiefs fear this is the first step toward charging municipal agencies for these services. A 2012 document prepared by the Nova Scotia Department of Justice suggests that, at the time, the province expected that it would bear the financial responsibility for specialized services provided under the Provincial Policing Services Agreement. The perception among the municipal police chiefs that there has been a change in the province's attitude in this respect appears to have some justification.

At the Commission's request, Barry MacKnight prepared a technical report on the structure of policing in Nova Scotia in 2020. Mr. MacKnight served 25 years in the Fredericton Police Force in New Brunswick, including seven years as chief of police. In his report, he explains that many of the municipal police agencies in Nova Scotia are comparatively small, and they concentrate their resources on providing basic police services to their municipality. While some have investigators and/or contribute officers to specialized teams or to functions such as Criminal Intelligence Service Nova Scotia, others do not have the capacity to do so. The arrangements by which they contribute and receive services are frequently informal. Similarly, we learned that integrated teams – such as the integrated RCMP and municipal police

teams in Halifax Regional Municipality and Pictou County – have changed over time, at least to some extent to reflect the preferences of the municipal chief and RCMP supervisor at the time.

Specialized police services include functions such as forensic identification services, emergency response teams, and major crime investigations. These functions are important, and it is crucial that they be available when needed, but they are not high-frequency needs in small communities. To avoid duplication and gaps in service, the location of and access to these services should be regulated by the Province of Nova Scotia. Care should be taken in determining these matters to avoid an urban bias, and particularly to avoid centralizing specialist services at the expense of their timely availability to rural communities.

LESSON LEARNED

Specialized policing services are integral to modern policing. These services should be organized to meet demand throughout the Province of Nova Scotia on an equitable basis.

Recommendation P.63

SPECIALIZED POLICING SERVICES

The Commission recommends that

The Province of Nova Scotia should ensure that specialized policing services are adequate, effective, and efficiently organized to meet the demand throughout Nova Scotia, whether by contract with RCMP or by other means:

(a) Clear and equitable guidelines should be established for how all police agencies may access these specialized services.

(b) These guidelines should also apply to the agency that supplies these services.

(c) Priority of access should be determined by prospective guidelines, not by the identity of the requesting agency or by personal relationships.

(d) A police agency that meets the criteria for access to these services should receive them, and arrangements should be put in place to ensure that disputes between provincial and municipal agencies about cost allocation do not create a barrier to access when needed.

Recommendation P.64

INTEGRATED TEAMS

The Commission recommends that

Police agencies that establish integrated or interoperable teams with other agencies should settle memorandums of understanding, policies, and procedures to govern the operation and management of these teams.

Study the Feasibility of Adopting a Unified Public Safety Answering Point

Public safety answering points (PSAPs), commonly known as 911 call centres, play an integral role in the community safety system. The 911 call-takers are often the first point of contact between trained emergency responders and community members. They must elicit information from callers who may be unsafe, frightened, or in pain. Their work entails a great deal of emotional labour and requires personal resilience, exceptional communication skills, and the capacity to capture and document information for first responders. Dispatchers ensure that responders receive information as they are responding to calls for assistance, document and share information provided by first responders, and play a large role in ensuring that emergency services responses are well coordinated. In Volume 2, What Happened, and in Part A of this volume, we discussed the crucial role played by 911 call centres, particularly the RCMP Operational Communications Centre (OCC), in

the critical incident response to the mass casualty. In these sections and in Part B of this volume, we also documented coordination challenges that arose from the fragmentation of PSAP services in Nova Scotia.

Nova Scotia 911 is administered by the Nova Scotia Emergency Management Office, under the Department of Municipal Affairs and Housing. Nova Scotia presently has four public service answering points. Three of these services are run by policing agencies. Integrated Emergency Services in Halifax is run by Halifax Regional Police and primarily serves the Halifax Regional Municipality. This centre provides dispatch services for RCMP members in the HRM as well as for Halifax Regional Police, fire, and ambulance services. Cape Breton Regional Police runs a PSAP in Sydney, primarily serving Cape Breton Island. The RCMP Operational Communications Centre was located in Truro at the time of the mass casualty but is now in Dartmouth. It serves as the 911 call answering point for most of rural Nova Scotia and provides dispatch services to RCMP members outside the Halifax Regional Municipality. Valley Communications runs a public safety answering point in Kentville. In addition to taking 911 calls, Valley Communications provides dispatch services for many fire brigades and some other responders in Nova Scotia. Many emergency response agencies have their own dispatch service, whether integrated into a public safety answering point (as with the RCMP Operational Communications Centre) or run as a standalone dispatch (as with Emergency Health Services and Truro Police Service).

The four public safety answering points provide overflow services to one another. This means that if, for example, all call-takers at the RCMP Operational Communications Centre are busy, a 911 call will automatically be transferred to another PSAP. This overflow mechanism was engaged at times during the mass casualty, with the result being that some 911 calls about the mass casualty were answered by public safety answering points in Halifax and Kentville. As explained in Part B of this volume, the overflow mechanism was also engaged on April 24, 2020, when the RCMP used the Alert Ready system to send an emergency alert about an unfolding incident in the Tantallon area of Halifax Regional Municipality. We stress that the evidence we received suggests that on both occasions, the total system was able to manage the volume of calls, due to the operation of the overflow mechanism. However, having some 911 calls about an unfolding incident answered by call-takers who lack situational awareness because these calls have been redirected to an overflow PSAP may adversely affect the capture and sharing of information about the incident.

The Nova Scotia Emergency Management Office establishes standard operating procedures for 911 call-takers and provides uniform 911 call-taking training. This training takes seven working days, with one week focusing on software training and testing, and two days focusing on intimate partner violence, family violence, and mental health crisis intervention. Individual PSAP operators add their own training, policies, and procedures to those supplied by the Nova Scotia Emergency Management Office, with the result that some practices and procedures are not uniform across agencies. We concluded in Part A of this volume that the RCMP Operational Communications Centre training, policies, and procedures are out of step with best practices elsewhere in Canada, and should be updated.

We also heard evidence of significant turnover in communications operators, burnout among communications operators, and a lack of institutional attention to and research about the work of communications operators. For example, in a small group session we heard from two acting Operational Communications Centre commanders, Mr. Bryan Green and Ms. Kirsten Baglee, both of whom had been on shift at the OCC in Truro during the mass casualty. They discussed the toll the mass casualty took and continued to take on the call-takers and dispatchers. Mr. Green stated:

> We have 50 operator positions at the OCC, full-time operator positions, and they were pretty much full, I believe, at that time. We had 50. We have 24 right now, full, 24 operator positions, most of those lost due to Portapique one way or the other. Some of those positions are still technically full, but there are people who are off sick, may come back, may not come back. So it's hard.[53]

Overall, the work performed by communications operators is highly gendered (most communications operators are women), extremely stressful, and undervalued in our community safety ecosystem. The problem of undervaluation may well be exacerbated by the fact that most public safety answering points are run by police agencies whose organizational strengths, managerial training, and focus lie elsewhere.

In a roundtable about critical incident response, including the role of communications operators, we heard from Ms. Kerry Murray-Bates, manager of Communications Services with the Toronto Police Service, which is the public safety answering point for the city of Toronto. Ms. Murray-Bates described the measures taken there to ensure that communications operators receive adequate training

and support, including wellness support, and to ensure that standard operating practices are robust, consistent, and scalable in such a way that the same procedures are followed for any emergency incident, regardless of scale. Nova Scotia should also implement these standards for all public safety answering points, whatever form they take in future. However, Nova Scotia's power to impose standards with respect to how the RCMP manages its Operational Communications Centre and supports its communications operators is limited by the constitutional principles described earlier in this chapter.

In order to address burnout, employee turnover, and recruitment challenges, it is necessary to increase the quality of training and supports offered to communications operators. It is also important, as a principle of equity, that communications operators in Nova Scotia enjoy consistent terms and conditions of employment. Consolidating public safety answering points into a single operator also secures consistency of policies and procedures with respect to matters such as how call-takers respond to callers, what information they elicit, and how information is documented. These are all areas where we have identified room for improvement.

However, centralizing public safety answering points into a single facility also has significant potential downsides. These include the potential loss of valuable employment opportunities in some communities (if a single location is chosen) and a loss of resilience in the 911 system (in the event that a localized systems failure affects the geographic area where a single facility is located).

The evidence we heard persuades us that attention to the model of public safety answering points is urgently needed. Finding the right model will ensure that PSAP employees are better trained and supported, first responders are more effectively supported in their work, and Nova Scotians are better served by their 911 call system.

LESSON LEARNED

The work performed by public safety answering point employees is highly gendered, extremely stressful, and undervalued in our community safety ecosystem.

Recommendation P.65

STRENGTHENING NOVA SCOTIA 911

The Commission recommends that

The Nova Scotia Emergency Management Office and Public Safety and Security Division of the Nova Scotia Department of Justice should study how best to ensure that recruitment, training, compensation, employee supports, policies, and procedures for public safety answering points are of a quality and standard that appropriately reflects the important role played by 911 call-takers in our community safety and well-being ecosystem.

Address Conflict Among Police Leaders

In Volume 2, What Happened, and Part B of this volume, we documented some of the evidence we heard about conflict among Nova Scotia police leaders. Witness accounts of the genesis and reasons for this conflict varied, but all agreed that the conflict arose between the RCMP and some municipal chiefs, that this conflict worsened after the mass casualty, and that to some extent it is a product of personality differences. Many witnesses and agencies also sought to reassure the Commission and the Nova Scotia public that this conflict is confined to leadership and does not affect relationships or behaviour in front-line policing. For example, in its final submission to the Commission, the Nova Scotia Chiefs of Police Association (NSCPA) states:

> We recognize that there is a perception before the Commission and within the public that the relationship between municipal police and RCMP is highly fractured. Fortunately, this is not our experience and our relationship is much stronger in reality than has been painted publicly.
>
> We assure the people of Nova Scotia that when there's an issue, we are there for each other in the interest of public safety as has always been the case. As has been stated before the Commission and the public we serve, we are stronger together and NSCPA remains committed to that philosophy.[54]

Similarly, in its final submission to the Commission the Truro Police Service said:

> A narrative has developed during Commission proceedings that the relationship between the TPS and the RCMP is very poor. This is a simplistic conclusion. The Commission heard from Chief MacNeil that the relationship between RCMP and TPS was good for many years, and still is good on the ground, in the sense that TPS and RCMP officers cooperate with and support each other in many ways in day to day operations.
>
> ...
>
> Having said the above, the TPS acknowledges that the relationship with the RCMP has deteriorated in the last couple of years. There are a number of reasons for this.
>
> Individual personalities and relationships have played a large role at the senior management level.[55]

In Chapter 10, which focused specifically on the RCMP, we recommended that RCMP leaders receive training in conflict resolution. In the present context, we add that all Nova Scotia chiefs, deputy chiefs, and their RCMP equivalent would be well served by acquiring similar skills. **The evidence that we received with respect to relations among Nova Scotia police leaders after the mass casualty leads us to conclude that while there were a number of specific incidents that increased tensions among police leadership after the mass casualty (including the RCMP's approach to the 2011 CISNS bulletin about the perpetrator, the introduction of a more formal approach to obtaining specialized policing services, and the relegation of RCMP members to associate non-voting status with the Nova Scotia Chiefs of Police Association), all those involved in these discussions had an opportunity to de-escalate these tensions. Their failure to do so is troubling.** While we are heartened by the reassurance that front-line co-operation remains strong, a breakdown in the relationships among police leaders inevitably affects the overall effectiveness of the community safety system. We note that there have been several transfers and retirements of H Division senior management since the mass casualty. While simply changing the individuals in the roles will not cure the systemic issues, it can provide an opening to build new trust and an opportunity for repairing these critical relationships. We invite the Province of Nova Scotia to take the lead in establishing a conflict resolution process that will allow police leaders to address lingering issues and forge a more constructive working relationship in the future.

LESSON LEARNED

When conflict among police agencies is allowed to persist, public confidence is undermined and operational effectiveness may be impeded.

Recommendation P.66

ADDRESSING CONFLICT AMONG POLICE AGENCIES IN NOVA SCOTIA

The Commission recommends that

(a) The Province of Nova Scotia should consult with municipal police leaders and RCMP H Division leaders to identify the issues that continue to cause conflict, and to establish a facilitated process for resolving them. Commitments and resolutions made as a result of this process should be documented, and the Province of Nova Scotia should hold police leaders accountable for implementing them.

(b) The Province of Nova Scotia should make in-person conflict resolution training mandatory for all current Nova Scotia chiefs and deputy chiefs and for any candidate who applies to one of these positions.

IMPLEMENTATION POINT

The Province of Nova Scotia should contract with an external provider that has an established track record in delivering effective conflict resolution training, to deliver this training.

(c) The Province of Nova Scotia should establish a dispute resolution mechanism by which an impartial and knowledgeable third party can resolve disputes among policing agencies, or between policing agencies and the Province of Nova Scotia.

(d) The Province of Nova Scotia should establish a policing standard that requires policing agencies to call on one another to provide backup or assistance when appropriate, and that requires those agencies called upon to provide that assistance to the extent of their ability to do so.

A Future for Policing in Nova Scotia

Some Participants invited us to make recommendations that would determine the future structure of policing services in Nova Scotia. For example, counsel for the RCMP submitted that:

> There are advantages to maintaining the RCMP in provincial policing. Its size allows for access to a diverse array of specialized services and training as well as a wealth of additional supports and resources when needed, such as greater agility and surge capacity for emergencies and major events. It provides a level of consistency in police services delivery through its standardized training, equipment and practices and a reduction in costs overall through cross-jurisdictional sharing of resources, infrastructure and information.[56]

The Atlantic Police Association invited us to recommend that "the RCMP discontinue contract policing (municipal and provincial policing) and focus on federal policing duties where their expertise is desperately needed."[57] Instead, the Atlantic Police Association suggested, policing in Nova Scotia should remain a municipal responsibility, with resources allocated regionally and an emphasis on community-based policing.

The Nova Scotia Chiefs of Police Association stated "that the current policing model in Nova Scotia is not sustainable"[58] and suggested that:

> [W]e support the exploration of more regional municipal police services in Nova Scotia, which would allow our current community-engaged policing approach to be expanded to more rural communities. This could mean the consolidation of current agencies and/or the expansion of single agencies. In this agile and adaptive approach, there would be a sharing of resources in communities of interest based on local needs without sacrificing local accountability. Further, it aligns with the current municipal policing approach and would not require dramatic transformational change.[59]

A number of recent Canadian reports have considered the value of continuing with RCMP contract policing, or adopting an alternative model. In 2022, the Routley Report, *Transforming Policing and Community Safety in British Columbia*, concluded that British Columbia should establish its own provincial police service:

> The Committee recommends that a new provincial police service take over services formerly contracted to the RCMP … Committee Members were of the view that transitioning to a new provincial police service will improve local accountability and decision-making, and responsiveness and connection to the community. The Committee emphasized that transitioning to a provincial police service is not a reflection on the work of individual RCMP officers; rather, it is a reflection of the challenges with governance and accountability with the current federal model.
>
> A new provincial police service will also improve consistency of services, training, oversight, standards, and policies across all police services in BC. The transition provides the opportunity to establish a provincial police service that is more reflective of the modern-day policing needs of British Columbians. As this will be a major change in the delivery of police services, Members stress that government must ensure an open, transparent and collaborative approach to working with partners, including local governments and Indigenous communities, that will be impacted.[60]

In Alberta, the provincial government is also studying a potential transition away from RCMP contract policing to a provincial police force.

In the Yukon, a 2011 review of the RCMP's provision of policing services, *Sharing Common Ground* (the Yukon Report), led to the creation of the Yukon Police Council. This council comprises six members, at least three of whom must be from local First Nations, and is chaired by the Yukon's senior civil servant with policing responsibilities. The council advises both the territorial government and the RCMP commanding officer in Yukon. The Yukon Police Council and other steps taken by the RCMP, Yukon government, First Nations government, and community members aim to:

1. Seek understanding and start the process that will foster positive relationships between the RCMP and citizens in order to increase public confidence in the police service; and
2. Renew relationships between the RCMP and Government of Yukon, First Nations governments, and citizens of the territory to ensure that all Yukon citizens receive quality police services.[61]

A 2014 evaluation of the implementation of the 2011 Yukon Report concludes that "The delivery of police services in Yukon has changed in many positive and

meaningful ways as a result of *Sharing Common Ground* implementation."[62] In particular, the 2014 evaluation finds:

> For the RCMP, whose practices and approaches were the main focus of the Review, the seeds of cultural change were planted early on in the process. Those who served in Yukon at the time of the Review, and particularly those involved in the review process and its implementation, have helped to ensure that this understanding and vision is shared and maintained with all employees. New practices have been adopted that reinforce the lessons learned through *Sharing Common Ground*, such as communicating to each arriving employee the Division's commitment to policing with the community, community involvement and the RCMP's core values, and clarifies what is expected of them during their service here.
>
> Implementation partners have expressed that they have seen major changes in how they interact with the RCMP and that they are pleased with the progress.[63]

In their expert report for the Commission, Dr. Christopher (Chris) Murphy, retired professor of sociology at Dalhousie University and University of King's College, and Cal Corley, CEO of the Community Safety Knowledge Alliance and former assistant commissioner of the RCMP, compare the benefits and drawbacks of three potential models for community-engaged rural policing: the RCMP detachment model; the local municipal police model; and the provincial police model. They conclude:

> Ultimately, any one of these three models could support a community-engaged policing service – but only if the police agency, the communities, and local/provincial governments are collectively committed to delivering the kind of policing rural communities require. Each model has its own advantages and disadvantages. It will be up to the communities themselves to decide the kind of police service they want to address their particular safety and security concerns.[64]

In Volume 4, Community, we described an ecosystem of community safety that decentres policing, and identified a range of important considerations for designing and sustaining such an ecosystem. We explained that the role of the police within a community safety ecosystem depends in part on how other parts of that ecosystem are designed, and in part on the answers we give to the question, "What

are the police for?" We emphasized that communities must have the greatest say in designing community safety systems, and that the work of redesigning these systems must begin before any definitive answer can be given to delineating the role of police within community safety systems.

In this Part, we have addressed the role and responsibilities of police directly. In Chapter 9, we adopted eight principles set out by Dr. Ian Loader for a democratically accountable, rights-responsive, equality regarding approach to policing. In Chapter 10, we made recommendations that the RCMP must implement if it is to more fully approach being such a police service. In this chapter, we have set out six strategies, each capable of rapid implementation, to improve the quality of police services in Nova Scotia.

The British Columbia, Alberta, and Yukon processes described in this section were the product of extensive community and expert consultations on the specific question of the structure of police services in their respective jurisdictions. Similarly, when the Halifax Regional Municipality moved to its present model of public safety, it did so on the basis of a consultation process that engaged one in every 60 residents in the municipality.

The evidence we have heard shows that Nova Scotians are deeply engaged with questions about community safety, and about the role of police in ecosystems of community safety. The choices that Nova Scotians make about other matters, such as how to allocate resources to prevention and early intervention services and how to ensure that community safety systems are collectively and individually accountable to the communities they serve, will guide Nova Scotians toward the best answers to questions about future models of policing services for their communities.

Sweeping amendments to the *Police Act* and decisions about police service providers and structures of policing should not be made until communities have had the opportunity to participate in a community-led process to discuss and decide these questions.

LESSON LEARNED

Transforming the structure of policing requires the collaborative work of community members, community safety experts, government, and police.

Recommendation P.67

THE FUTURE STRUCTURE OF POLICING IN NOVA SCOTIA

The Commission recommends that

The Province of Nova Scotia should within six months of publication of this Report establish a multisectoral council comprising representatives of municipal police agencies and RCMP, community safety experts, and diverse community representatives to engage with community members and experts and review the structure of policing in Nova Scotia. This council should make recommendations that can be implemented before the 2032 expiration of the Provincial Police Services Agreement.

Part D:
Everyday Policing Practices

Introduction

Introduction

In this final Part of Volume 5, we draw a number of threads together to consider the question: How do everyday policing practices contribute to the overall effectiveness and legitimacy of the police? To answer that question, we must consider the role of discretion in front-line policing. **We explain that low-visibility decision-making is a defining feature of police work and a particular characteristic of the work performed by front-line police officers. We then review the evidence we heard which persuades us that it is necessary to focus on everyday policing practices and the exercise of police discretion in low-visibility environments. Finally, we offer five strategies for improving the quality of everyday policing practices in Canada.** These five strategies address:

1. Selecting police students and police recruits
2. Police education
3. Note taking and record keeping
4. Front-line supervision and feedback
5. Community-engaged everyday policing

We draw particularly on evidence we heard about the RCMP's approach in several of these domains, information about police responses to concerns about the perpetrator of the April 2020 mass casualty, and case studies and examples that we heard of other instances in which police have misapprehended the risk to women's safety.

These five strategies are of general application to Canadian policing agencies. Collectively, these five strategies will assist Canadian police services, particularly the RCMP, to offer services that approach the standards established by the eight principles of policing that we adopted in Part C of this volume. In the concluding section of this Part, we consider the relationship between everyday practices of policing, equality, and securing community safety. We identify the need to shift

police officers' understanding of their role to acknowledge the primacy of securing the safety of those who experience violence. We also identify the central role played by misogyny within the police failings that are documented throughout this report. We suggest that countering misogyny, racism, homophobia, and other attitudes that undermine universal human dignity must be placed at the centre of each of the everyday policing practices identified in this Part.

CHAPTER 12

Police Discretion

Understanding Police Discretion

Discretion is integral to police work, and exercising discretion is a particular characteristic of the work performed by front-line police officers. Dr. Benjamin Goold, professor at the Allard School of Law, University of British Columbia, explains in an expert report prepared for the Commission that **police discretion is best understood as a permission which is extended by society to individual police officers to use "their considered judgment in certain ways in certain situations."**[1] This understanding of discretion as a permission to act connects the legitimate exercise of discretion to the special knowledge and expertise of police officers. Conversely, when police make decisions in realms outside their special knowledge and expertise – where, for example, they have not been adequately trained to exercise considered judgment – their exercise of discretion does not have a sound basis. The link that Dr. Goold draws between legitimate discretion and the cultivation of special knowledge and expertise is important, because it suggests the crucial role of police education and internal supervision in developing effective daily policing practices.

Police Discretion and Low-Visibility Decision-Making

Many researchers and policy-makers use the term "discretion" to refer to any decision made by a police officer. In his expert report, Dr. Goold uses the term more strictly, to describe a decision based on special knowledge or expertise within an area that law and community standards establish as being appropriate for the exercise of police decision-making. We differentiate between these two meanings by using "discretion" in its usual sense of decision-making and

"legitimate discretion" to mean an exercise in police decision-making that meets Dr. Goold's criteria.

The phrase "low-visibility decision-making" refers to the decisions front-line police make that are rarely scrutinized by any external body. Many of these decisions are decisions not to act: for example, a decision to overlook a driving infringement, or a decision not to follow up on a complaint made by a community member. Dr. Goold observes that the concentration of low-visibility decision-making responsibility in front-line policing means that front-line members exercise "significant amounts of unsupervised authority."[2]

There is an immense body of research on police discretion, much of it focusing on how external bodies, such as courts and Parliament, and oversight agencies, such as police complaints commissions, can better regulate and review police decision-making. An influential strand of this work advocates removing certain kinds of discretion from the police, for example, by prohibiting street checks or by establishing mandatory charging policies in certain situations. This research and policy work particularly emphasizes problematic exercises of police decision-making, many of which are police practices that harm substantive equality because of their disproportionate adverse impact on Black, Indigenous, or racialized Canadians and on women, girls, and 2SLGBTQI+ (Two Spirit, lesbian, gay, bisexual, transgender, queer, intersex, and additional sexually and gender diverse) people. These studies have made important contributions to public and policy understanding of inequitable police practices and their impact on equality and social cohesion. For example, Canadian criminologist and assistant professor at Toronto Metropolitan University Dr. Kanika Samuels-Wortley has written, "Canadian police services often promote multicultural and equity values, but researchers have long identified practices that contribute to the differential treatment of Black and Indigenous populations, in comparison to their White counterparts."[3] We draw on research about the relationship between police exercises of discretion and structural inequality throughout this Report, including in this Part.

Legal and constitutional principles, including *Charter* rights and freedoms, set limits to police discretion. As Dr. Goold observes:

> [B]y opening the door to constitutional claims in the context of criminal proceedings, the *Charter* has brought with it a greater focus on the nature and extent of police discretion in Canada. Combined with growing public concern over abuses of police power, this has led to a situation in which the courts are now routinely asked to consider whether an exercise of police discretion has violated a suspect's *Charter* rights, exposing many of the "serious deficiencies in the scattered collection of statutory and common law rules that make up the law of police powers in Canada."[4]

The legal responsibilities of front-line police are set out in a range of laws, including Police Acts. For example, sections 18 and 37 of the *Royal Canadian Mounted Police Act* state that RCMP members have duties to preserve the peace, prevent crime, and apprehend criminals, which must be performed promptly, impartially, diligently, and with respect for the rights of all persons and the importance of maintaining the rule of law. Provincial Police Acts vary as to how specifically they set out police duties. However, it is also important to acknowledge that external reviews of police decision-making are the exception and most exercises of police discretion will never come to any form of official attention or review.

Ethnographic studies of front-line policing establish that discretion is intrinsic to police work. Although law and policy have removed discretion from some areas of police activity, it is not possible to stop police exercising decision-making power in how they approach their work. The police exercise of decision-making power goes well beyond the high-visibility choices police make about whether to arrest someone, or what charges to lay. **Every day, front-line police make decisions about matters such as what questions to ask a complainant or person of interest; what follow-up needs to be done about a particular matter; how to categorize a complaint that doesn't lead to further investigation or charges; what to write in their notebooks; when to make a more formal record of their activities; which streets to walk or drive along; when to stop and look more closely at something they have observed; and when to initiate an interaction with someone they have observed. These decisions have a significant impact on what crime and social problems come to broader official attention and how effectively social problems are countered. They also affect community trust in the police.**

Dr. Richard Ericson, who was a professor at the Centre for Criminology and Socio-legal Studies at the University of Toronto, observed on the basis of an ethnographic study of the patrol work of an Ontario police force that "[a] host of decisions about mobilizations and information-gathering form the bulk of all decisions by patrol

officers."[5] Dr. Ericson explained that the concentration of discretion in the front lines of policing is a distinctive feature of police organizations: "The police organization differs from most other organizations in the extent to which essential decisions and the input of knowledge occur among the lowest-ranking members and filter upwards."[6] This characteristic of police work gives front-line police a great deal of power to decide what information is captured, which in turn forms the basis of official action by others: "[T]he police officer has control over the production of 'facts' about a case, and this control of knowledge becomes a very potent form of power."[7] What information the police elicit and record through the questions they ask (or don't ask); the evidence they collect (or don't collect); the notes they write (or don't write); and the electronic records they input (or don't input) becomes the basis for action or inaction throughout the system. In this sense, Dr. Ericson observes, "a situation with many possible interpretations, each with many possibilities for investigation, is transformed into one interpretation and one course of action."[8]

How front-line police exercise their discretion on a daily basis has deeper implications for how effectively police agencies serve their communities. In Part C of this volume, we recommended that Canadian police agencies and government adopt eight principles of policing that were defined by Dr. Ian Loader, professor of criminology at the University of Oxford. These principles are:

1. The basic mission of the police is to improve public safety and well-being by promoting measures to prevent crime, harm and disorder.
2. The police must undertake their basic mission with the approval of, and in collaboration with, the public and other agencies.
3. The police must seek to carry out their tasks in ways that contribute to social cohesion and solidarity.
4. The police must treat all those with whom they come into contact with fairness and respect.
5. The police must be answerable to law and democratically responsive to the people they serve.
6. The police must be organized to achieve the optimal balance between effectiveness, cost-efficiency, accountability and responsiveness.
7. All police work should be informed by the best available evidence.
8. Policing is undertaken by multiple providers, but it should remain a public good.[9]

The decisions made every day by front-line police officers affect the extent to which police agencies adhere to several of these principles. In particular, how front-line police exercise their discretion affects the extent to which police work contributes to social cohesion and solidarity; the extent to which community members who interact with police feel they have been treated fairly and respectfully; the extent to which the police are or can be answerable to law and democratic processes with respect to the work they do; the balance of effectiveness and other values achieved by police; and the extent to which police work is informed by the best available evidence.

Debates about the nature of police discretion are important but they can feel very abstract; everyday policing practices are not. In the next section, we explain why it is important to focus on improving police decision-making. The following chapter sets out five concrete areas in which we can better prepare front-line police to exercise legitimate discretion to further the eight principles of policing we have adopted in this report. The strategies set out here will also ensure that front-line police decision-making is routinely supervised so that shortcomings in judgment, behaviour, or practice can be identified and addressed before they become entrenched in an officer's working personality or accepted in workplace culture.

The Importance of Improving Low-Visibility Decision-Making

Our process demonstrates that the police power to shape the official record by the manner in which front-line officers exercise discretion is not merely a theoretical concern. Questions arose in our process about the following:

- what was or was not said by community members to various police officers in complaints about the perpetrator's behaviour;
- what investigative steps were or were not taken (and what steps could or could not have been taken) in response to information received by police about the perpetrator;
- the nature of the perpetrator's relationships with particular police officers;

- how front-line police interacted with the perpetrator including at times when he behaved aggressively toward them;
- whether they would have interacted similarly with a racialized person exhibiting similar behaviour; and
- whether they would have interacted similarly with the perpetrator if he had not presented as a privileged, relatively wealthy person.

These are questions about how police exercised their discretion. They also point toward concerns about whether police decisions with respect to the perpetrator were the product of legitimate exercises of discretion, in Dr. Goold's sense of the term.

In Volume 3, Violence, we identify shortcomings in RCMP members' responses to public complaints about the perpetrator in the years prior to the mass casualty. We explain that the RCMP's failure to recognize and act on community members' fears about the perpetrator is not unusual, but is consistent with a well-documented pattern of Canadian police often failing to recognize or respond adequately to gender-based violence and intimate partner violence. In Volume 4, Community, we explain that the task of improving responses to gender-based, family, and intimate partner violence does not rest only with police. Individuals, communities, businesses, and other government agencies all have an important part to play.

In Part C of this volume, we explain that police nonetheless play a crucial role in this ecosystem. We quoted Dr. Loader:

> [T]hink of the difference between a victim of domestic violence or "hate crime" confronted by a police force that treats such violence as "rubbish work" and one that publicly and through its actions treats the problem as serious crime. Policing, in this respect, is never simply an answer to the question "How safe am I?" The police also, in a limited but profound way, help individuals to answer such questions as "Where do I belong?" and "Who cares about me?"[10]

In our process, we heard that police failures to hear and respond effectively to community members who expressed fear of the perpetrator or sought to report his violence were echoed in other incidents that were well known to, and widely discussed among, community members and experts who contributed to our work. Two other examples from rural Nova Scotia, which are separate from the perpetrator of the mass casualty, arose repeatedly in these conversations: the RCMP

response to complaints made in 2017 by Susan (Susie) Butlin, of Bayhead, Colchester County, about her neighbour Ernie Duggan before Mr. Duggan killed Ms. Butlin; and the RCMP's treatment in 2007–8 of Digby County resident Nicole Doucet (widely known as Nicole Ryan), who was subjected to violence including coercive control by her husband, Michael Ryan. In this section, we summarize what we learned about each of these cases before supplying an account of some other concerns that were raised in our process about how police exercise their discretion. We draw on these examples in the ensuing discussion of strategies for improving everyday policing practices. However, first we recap our earlier findings (in Volume 3) regarding the perpetrator's ability to avoid accountability for his violence toward others.

The Perpetrator of the April 2020 Mass Casualty

Earlier Findings

In Volume 3, Violence, we found that:

- There was intergenerational violence in the perpetrator's family. The perpetrator was physically and emotionally abused as a child and, as an adult, he was violent toward his father and uncle Glynn.
- As an adult, the perpetrator developed an alcohol use disorder and was known to become violent when he drank to excess.
- The perpetrator's pattern of violent and intimidating behaviour was facilitated by the power and privilege he experienced as a white man with professional status and substantial means.
- The perpetrator had a history of financial misdealings that included manipulative and predatory patterns of behaviour.

The perpetrator witnessed family violence, including intimate partner violence and gun violence, in his childhood home and was himself subjected to various forms of abuse and violence as a child. He was abused by his father, and the violence in the perpetrator's family extended back several generations. We noted that as an adult, the perpetrator's violent and coercive behaviour extended ever outward:

to his intimate partners; to relatives, friends, neighbours, and business associates; to his patients and other vulnerable and marginalized people in the communities where he lived and worked; to individuals in positions of power and control over him, such as police officers and colleagues participating in the review of his misconduct at the Denturist Licensing Board of Nova Scotia; to perpetrating a mass casualty. As the recitation of the various forms of violence that the perpetrator committed against partners, family, co-workers, employees, clients, and strangers shows, many people were aware of his violent tendencies over many years.

The perpetrator's violence was reported to, investigated by, and in some cases witnessed by the police with minimal repercussions or intervention. We documented 12 interactions between the police and the perpetrator from 1996 to February 2020.

We described in addition the Sutherland Lake incident in which the perpetrator assaulted his common law spouse Lisa Banfield in front of witnesses in approximately 2003, and how the circumstances surrounding police involvement in this incident remain unclear. It does not appear that anyone connected Ms. Banfield to support services (such as a shelter) in connection with that incident. Because of her fear of the perpetrator harming her family, it is unlikely she would have availed herself of such services in any event.

The perpetrator came into contact with police on several other occasions: he was convicted of assault of a minor, and he assaulted a friend who declined to press charges. He threatened to kill his parents. He prevented police officers from exiting the parking lot of the clinic and, on the same day, was aggressive toward an RCMP member who issued a speeding ticket to him. An informant alleged he threatened to kill police.

We described the assault on Vincent McNeil, the perpetrator's neighbour in Dartmouth, and the conclusion of Halifax Regional Police Cst. James Henry MacVicar that "it was more of a civil matter."[11]

With respect to the assault in October 2000 on his friend Dave Quinlan, Mr. Quinlan reported it to Halifax Regional Police (HRP). This report meant that the incident was recorded in the Versadex database, which is the police records management software used by the HRP, as well as other municipal agencies. The RCMP H Division uses a different records management software for their police records (the Police Reporting and Occurrence System, or PROS) and did not have independent access to the Versadex database at the time of the mass casualty. This fact speaks to the challenges that arise from mismatched database programs, record retention,

and access policies / interoperability. The lack of communication, including systems communication, between policing agencies working in close geographic proximity is an important piece of the missed intervention opportunities in his interactions with police.

We also noted in Volume 3, Violence, that the perpetrator assaulted a teenage boy named Matthew Meagher in 2001. In 2002, he pled guilty to assault and received a conditional discharge with nine months of probation. Pursuant to the probation order, the perpetrator was prohibited from possessing any firearms, prohibited weapons, ammunition, or explosive substances for the duration of his probation.

In 2010, the perpetrator's father, Paul Wortman, called the Codiac RCMP in Moncton, New Brunswick, to report that the perpetrator had threatened to kill his parents. He also reported that he had seen firearms at the perpetrator's Portapique residence five or more years earlier. Cst. Len Vickers of the Codiac RCMP detachment shared the complaint with the HRP, which assigned Sgt. Cordell Poirier as the lead investigator. As described in Volume 3, in the very early hours of June 2, 2010, Sgt. Poirier attended at the perpetrator's Dartmouth residence and spoke with Ms. Banfield, who told him the perpetrator was passed out drunk in bed and that there were no firearms in the home. Sgt. Poirier did not speak to the perpetrator; Ms. Banfield discouraged him from entering the home out of fear that the perpetrator would react violently if he became aware of the police presence. She testified:

> He had the handgun by the nightstand, and he said, "If any police come I'm shooting." So when they asked me that, I didn't want them to go in because I didn't want them to get hurt.[12]

Sgt. Poirier searched the Canadian Police Information Centre and the Canadian Firearms Registry Online, concluding that the perpetrator had no registered firearms.

The HRP made a notation in the perpetrator's CPIC file in June 2010 that the perpetrator was "firearms interest to police."[13] As suggested by counsel for the Participant coalition of Avalon, Wellness Within, and Women's Legal Education and Action Fund, had the Canada Border Services Agency (CBSA) accessed the database that included this notation, it would have affected the perpetrator's NEXUS application and potentially had other consequences for his frequent border-crossing activities in the period in which he smuggled firearms used in the mass casualty into Canada.

Sgt. Poirier returned to the perpetrator's Dartmouth residence the day after receiving the threats complaint. No one answered the door, but the perpetrator called him as he was leaving, saying that he was in Portapique. Sgt. Poirier requested follow-up from RCMP in Colchester County, speaking with Cst. Gregory (Greg) Wiley. Cst. Wiley's evidence was that he was unable to find his notes from this incident and did not have any recollection of visiting the perpetrator's property in response to Sgt. Poirier's call. Cst. Wiley's lack of notes is in contrast to the notes taken by Sgt. Poirier. His notes reflect that he called Cst. Wiley on July 9, 2010, and left a message requesting an update. When Sgt. Poirier eventually spoke to Cst. Wiley on July 17, 2010, he learned that Cst. Wiley had not yet spoken to the perpetrator. In Volume 3, we found that Cst. Wiley described the perpetrator to Sgt. Poirier as a friend. Sgt. Poirier heard nothing further from Cst. Wiley. Sgt. Poirier did not lay charges against the perpetrator for uttering threats, as the threats were of an "in-direct and [veiled] nature."[14] The file was closed on August 26, 2010. Ms. Banfield's evidence was that an officer, whom we find to have been Cst. Wiley given his other visits to the property, had attended at the Portapique residence but he did not conduct a search. The precise date on which Cst. Wiley made this visit to the Portapique residence is unclear from the evidence available to us.

Less than a year later, in May 2011, an unknown source informed Cpl. Gregory (Greg) Densmore of the Truro Police Service (TPS) that the perpetrator had said he wanted to "kill a cop" and was in possession of at least one handgun and several long rifles, which he was transporting between the Atlantic Denture Clinic and the perpetrator's Portapique residence. The source said the rifles were stored in a compartment behind the flue at the perpetrator's Portapique residence. The source said the perpetrator was "under a lot of stress lately and starting to have some mental health issues."[15]

As a result of this information, Cpl. Densmore issued a Criminal Intelligence Service Nova Scotia (CISNS) bulletin (as discussed in Volume 3). Cpl. Densmore filed this information in the TPS database as a "source debrief" report and relayed it to S/Sgt. Bill Morris of HRP. S/Sgt. Morris shared a copy of Cpl. Densmore's "source debrief" report within HRP. Sgt. Poirier read the "source debrief" report written by Cpl. Densmore of TPS and, given his investigation of the perpetrator's threat to kill his parents in 2010, Sgt. Poirier contacted the Bible Hill detachment. It had been less than a year since that complaint when the HRP, via the Codiac RCMP detachment, also received information from Paul Wortman that the perpetrator had firearms.

Sgt. Poirier's notes indicate that he contacted acting supervisor Cst. John MacMinn of the Bible Hill RCMP detachment after receiving the 2011 CISNS bulletin and provided him with a summary report of the 2010 investigation, noting that Cst. Wiley (of the Bible Hill detachment) had followed up on it. Sgt. Poirier wrote that Cst. MacMinn said he would follow up with Cst. Wiley and then contact Sgt. Poirier with an update. Sgt. Poirier said he never received an update from Cst. MacMinn. Cst. MacMinn told us, "I don't recall telling Sgt. Poirier that I would call him back. I recall telling him that I would pass on his message to Cst. Wiley, which I did."[16] Cst. Wiley said he had no recollection of any dealings with Cst. MacMinn nor of speaking with anyone from the Bible Hill detachment with respect to the perpetrator during this period. He says that he was not tasked with investigating the possession of firearms and not asked to interview the perpetrator's neighbours in this regard. Cst. Wiley told the Commission that he received an email saying that the perpetrator had "threatened somebody or something out in New Brunswick."[17] In Volume 3, we concluded that Cst. Wiley received the bulletin. There is no evidence that this bulletin led to a meaningful investigation of the perpetrator by any police service. Nor was it provided to the CBSA.

In Volume 3 we also described Brenda Forbes's 2013 report to the RCMP regarding an assault on Ms. Banfield and the inadequate response by RCMP members who received this complaint, and a 2019 incident in which RCMP members responded to Portapique and a witness (whose name is anonymized as II) attempted to report that the perpetrator had sexually assaulted her, but was deflected from making this report by another community member. The RCMP failed to follow up on this incident, too.

Others saw him commit assaults or were assaulted by him or harassed by him but did not report these incidents. The Avalon Report documents a pattern of violence by the perpetrator toward marginalized clients, particularly African Nova Scotian women and women who exchange sexual activity for payment.

In each instance in which serious allegations against the perpetrator came to police attention, police made decisions about how to respond to these allegations, including about the nature of the complaint and whether to investigate further. The only instance in which charges resulted was in relation to the assault on a young man, Matthew Meagher. In other instances, police either failed to recognize the seriousness of the threat presented by the perpetrator and so failed to take further steps, or they were thwarted in their efforts to take additional steps. A failure of record keeping and coordination meant that the pattern of complaints against the perpetrator was not recognized, and each incident was dealt with in isolation from

others. The exception to this overall pattern was Sgt. Poirier's 2011 recognition that the CISNS bulletin related to the same person (the perpetrator) against whom he had investigated the threats complaint the previous year. His efforts to follow up on this recurrent concern appear to have been defeated by a failure of coordinated follow-up across police agencies. Taken together, the failure to follow up on all of these serious allegations constitutes a series of missed red flags, in each of which police failed to recognize the gravity of the perpetrator's violence toward others.

In Volume 3, Violence, we found that:

> The perpetrator's violence and illegal firearms came to the attention of police on repeated occasions in the years prior to the mass casualty. Due to a number of structural and systemic problems, these serious allegations regarding a single individual did not prompt an appropriate police response. These structural problems are: implicit bias in police decision-making, failure to identify and address gender-based violence, the lack of effective investigation by the police forces, the lack of detailed notes by RCMP members and ineffective supervision, the short period of record retention, the siloing of information between agencies, whether due to different database systems or failure to share information, and lack of effective communication between the HRP, the Truro Police, and the RCMP.
>
> A cultural shift is required so that (a) our institutions accommodate accessible, safe and credible reporting mechanisms, (b) promoting crime and community safety becomes a shared responsibility, and (c) existing systemic biases favouring privileged perpetrators are addressed.

Here, we build on this finding by identifying a key lesson learned for policing and making a recommendation about information sharing. The importance of information sharing among police services has also been identified in past reports and inquiries. A recent example is the 2022 Ontario Office of the Chief Coroner's 2022 inquest into the deaths of Carol Culleton, Anastasia Kuzyk, and Natalie Warmerdam (Renfrew County Inquest).[18]

LESSON LEARNED

Perpetrators of violence do not necessarily remain within a single police jurisdiction. Effective information sharing among police agencies is essential to ensure that patterns in perpetrator behaviour can be recognized.

Recommendation P.68

INFORMATION SHARING

The Commission recommends that

(a) Police agencies in Nova Scotia work with the Nova Scotia Department of Justice to establish shared standards for the collection, retention, and sharing of information by police agencies.

(b) Police agencies in Nova Scotia work with the Nova Scotia Department of Justice to establish policies and procedures for raising concerns when a member of one police agency believes that a member of another police agency may not have acted on information that flags a significant risk to community or police safety.

Ms. Susan (Susie) Butlin

This summary is based on information provided in an RCMP independent officer review dated December 19, 2018.[19]

On August 7, 2017, at 2:23 pm, Susan Butlin of Bayhead, Colchester County, Nova Scotia, called 911 and spoke with a call-taker at the RCMP Operational Communications Centre, then based in Truro, Nova Scotia. The call was recorded and later transcribed. During the call, Ms. Butlin stated that she wished to make a complaint about a sexual assault that had occurred in July. She named her neighbour as the perpetrator, provided some details about the incident, and requested that a female member be dispatched. The call-taker stated that no women were scheduled to be on shift at that time, and suggested that Ms. Butlin speak with a male member who would call her, reassuring her that "they're pretty empathetic."[20]

Cst. Patrick Crooks from the Bible Hill detachment spoke with Ms. Butlin by phone that day. At the end of that conversation, Cst. Crooks "informed [Ms.] Butlin that based on what she stated there was no criminal offence and referred her to the Peace Bond process. [Ms.] Butlin responded that this was the reason she had requested a female member."[21] Cst. Crooks therefore arranged to have a female member follow up with her.

At 6:37 pm on August 7, 2017, Ms. Butlin spoke with Cst. Cristiana Whalen from Bible Hill detachment in Ms. Butlin's home near Tatamagouche, Nova Scotia. This conversation was recorded, and later transcribed. Ms. Butlin advised Cst. Whalen that she was "quite shocked" and "totally floored" when her neighbour, Ernie Duggan, crudely initiated sexual activity after inviting himself to her home for a drink. She clearly stated that she was not open to that activity and walked away from him. When Mr. Duggan did not leave or desist, she became "friggin scared" and engaged in some sexual activity "to keep things calm … you don't know … what in the hell this neighbors gonna do to ya."[22] Ms. Butlin reiterated in response to follow-up questions that when the sexual touching occurred she told Mr. Duggan clearly that she was not interested in sexual activity, that when he did not listen or desist, she became "really, really scared" and "trying to keep him calm, to think, okay, is he gonna jump me or what."[23] Afterwards, she "just kept saying no." On further follow-up, she explained, "I was scared, because he's a very strong man … and he was really really drunk, and when you put those two things together, you don't know what they're gonna do."[24]

Ms. Butlin explained that after the sexual touching occurred, she moved to another area of her home. Mr. Duggan followed and made further vulgar remarks, in response to which Ms. Butlin insisted that she was not interested in sexual activity and he should go home to his wife.

The transcript records that Ms. Butlin told Cst. Whalen that, as Mr. Duggan left, he said, "well, I may be back ..." and that she took this as a threat.

After receiving this statement, Cst. Whalen confirmed that "based on the information at hand there was no criminal offence, and that she could pursue via Peace Bond if she wished." A note within the independent officer review states that "[t]he member and supervisors after review came to the conclusion that the sexual contact did not appear to be forced and was consensual."[25]

No charges were brought against Mr. Duggan and there is no record of the RCMP having sought to interview Mr. Duggan about these allegations.

On August 10, 2017, Ms. Butlin filed her own information for a peace bond. In the grounds for seeking a peace bond, she reiterated many of the details she had provided to the RCMP. Mr. Duggan was served with a summons for the peace bond on August 16, 2017.

On August 21, 2017, Mr. Duggan's wife, April Duggan, called 911 "in distress" to report that she thought her husband was going to kill Ms. Butlin. Ms. Duggan reported having fled her family home after Mr. Duggan had kicked in a locked door and that she was terrified. She expressed fears for her own safety and that of Ms. Butlin, and also that Mr. Duggan may harm himself. Ms. Duggan subsequently called 911 again to report that Mr. Duggan may have obtained a gun.

Cst. Rodney MacDonald and Cst. Stuart Beselt attended the Duggan residence. Because of the lengthy response time anticipated, 911 dispatch called Ms. Butlin and, after confirming that there was no immediate disturbance at her residence, advised her to "hold tight there and just ... I'm not trying to scare you or anything there, but if you just want to lock your doors and stuff, just, just until officers come out"[26] to deal with Mr. Duggan.

RCMP members Cst. MacDonald and Cst. Beselt located Mr. Duggan and spoke to him in person for about 20 minutes. He was intoxicated and continued drinking while speaking with them. He assured the members that "he would 'never hurt anyone.'"[27] Cst. Beselt also spoke to Ms. Butlin, but took no notes of this conversation.

After the RCMP members left Mr. Duggan they met with Ms. Duggan at a different location. While RCMP remained in the area, they spotted Mr. Duggan's vehicle on the move. They investigated, and arrested and charged Mr. Duggan for impaired operation of a motor vehicle.

On August 26, 2017, Ms. Butlin reported that she had been receiving text messages from Mr. Duggan "trying to intimidate her from going through with the Peace Bond process."[28] She advised the 911 call-taker that she had told Ms. Duggan she didn't want to hear from the Duggans. She stated that she had called Bible Hill RCMP detachment on August 25, 2017, and left a message for Cst. Whalen (who had taken her statement on August 7), but that no one had returned her call. Cst. Greg Wiley was assigned to respond to this call. He telephoned her and reviewed the text messages that Ms. Butlin had received. Cst. Wiley "determined there was no basis for charges."[29] The internal review report notes that Cst. Wiley ascertained that Ms. Butlin "had not directly advised DUGGAN to stop contacting her."[30]

On August 29, 2017, the RCMP received an email from a Crown attorney. The email was sent at the request of the judge who had heard the application for a peace bond. This judge suggested that the police look into the matter "as it was likely more than a Peace Bond."[31] Sgt. Duane Cooper reviewed the file and subsequent criminal harassment complaint and "supported the decision not to pursue charges."[32] He assigned Cst. Lori Thorne and Cst. Gavin Naime to review the file.

On August 30, 2017, Cst. Naime conducted a further review and "concurred with previous investigators that there were no grounds for charge."[33] He documented his reasons for this conclusion, including that "[Ms.] Butlin's statement provides no evidence of sexual assault, rather consensual touching."[34] On this day, Ms. Butlin's application for a peace bond was heard. It was adjourned to September 13 and subsequently to October 3, 2017.

On September 13, 2017, Cpl. Neil Wentzell documented that Ms. Butlin "had contacted him regarding not being satisfied with police response to her sexual assault complaint. He reviewed the file in full and agreed no charges were warranted."[35] This corporal met with Ms. Butlin on September 14, 2017, to explain his review and decision not to charge.

On September 17, 2017, Mr. Duggan murdered Ms. Butlin with a shotgun. At the time of the RCMP review of these matters, Mr. Duggan had been charged but the case had not been tried. The RCMP charged Duggan with first-degree murder; he pled guilty to second-degree murder and was sentenced to life in prison with no

possibility of parole for 20 years. Ms. Butlin was 58 years of age at the time of her death.

After Ms. Butlin was murdered, the RCMP conducted an independent officer review of the RCMP's response to the complaints laid by Ms. Butlin and Ms. Duggan. The independent officer review identifies nine areas for improvement:

1. Incomplete investigation of Ms. Butlin's complaint of sexual assault. The report attributes this failure to "a performance gap" that arose because "the involved members were not fully aware of the intricate steps and nuances of investigations as it relates to the complex area of sexual assaults." The report identifies investigative steps that should have been taken but weren't including: seeking statements from other witnesses, obtaining evidence in the form of text messages and social media information, conducting a criminal record check on Mr. Duggan, interviewing Mr. Duggan, failing to follow up on Ms. Butlin's description of threats made against her and her family and claims of malicious property damage, and submitting a ViCLAS (Violent Crime Linkage Analysis Software) report. The independent officer review also documents that the responding members failed to adopt a trauma-informed approach, that Ms. Butlin should not have been asked to discuss specifics about the sexual assault in a telephone interview, and that she was not informed that a decision had been made not to charge Mr. Duggan.
2. Failure to clarify or seek further detail about some matters in Ms. Butlin's audio-recorded statement, although the review also praises some aspects of this interview.
3. "Investigator bias." The independent officer review identifies that, "throughout the course of the Sexual Assault investigation, including supervisory reviews, there appears to be several areas where both investigators and supervisors had difficulty understanding the perception of events from [Ms. Butlin's] perspective." The examples provided in the review relate to these members' and supervisors' misunderstanding of the law of consent, including their failure to appreciate the significance of Ms. Butlin's statement that she clearly said no to Mr. Duggan's requests, and her evidence about her fear of Mr. Duggan and the impact of that fear on her behaviour during the sexual assault.
4. Incomplete investigation of the incident that led to Mr. Duggan's arrest for impaired driving, including the failure to follow up on information provided

by Ms. Duggan and Ms. Butlin about other offences committed by Mr. Duggan and the failure to take witness statements. This particularly included the failure to follow up on Ms. Duggan's expressed fear that Mr. Duggan had acquired a firearm.

5. The incomplete investigation into Ms. Butlin's August 26 complaint of criminal harassment. The independent officer review observes: "Given the ongoing events since the initial sexual assault complaint, these allegations should have been taken seriously and a thorough investigation conducted." The report specifically notes that the RCMP member's report of what Ms. Butlin said is in conflict with her recorded statement to the 911 call-taker and that "a recorded statement would provide a formal record of what exactly was said and eliminate any question that the investigating member was either not told or did not fully understand what [Ms. Butlin] was reporting."
6. Deficiencies in documentation. "All files reviewed had deficiencies noted in terms of documentation. This is true in relation to both written reports as well as officer's notes, both for investigating members and supervisors." Indeed, the review report finds virtually no documentation of file reviews by a case manager or supervisor. The independent officer review explains:

> Without effective documentation it is difficult, if not impossible, to determine if appropriate actions were taken by investigating members. Often decisions are made on the information an officer knew at that specific time, which is key to have fully articulated within any officer's notes or reports.

7. Supervision. The independent officer review identifies that supervisor involvement is apparent on numerous occasions throughout the file. "Despite this, the above noted issues in relation to quality of investigation and lack of action in relation to the allegations were not addressed."
8. Peace bond process. When Ms. Butlin was referred to the peace bond process, she should have been given a pamphlet or directed to the website at which the process is explained.
9. Training. None of the involved members had training in sexual assault investigations or advanced investigative training.[36]

The independent officer review characterizes the shortcomings in member response in this instance as being

> performance related vs intentional. Investigators and supervisors from the onset all appear to have truly believed that the sexual interaction between the victim and suspect was consensual and that as a result no offense had been committed. This original decision appears to have influenced the police's perception of the victim and suspect's relationship going forward.[37]

The independent officer review makes several recommendations:

- Increase availability of advanced investigative training for front-line members.
- Investigative training for supervisors.
- Referral to/use of the *Best Practice Guide for Sexual Assault Investigations* prepared by the RCMP National Headquarters Sexual Assault Review Team (SART), including the checklist in that guide.
- Identify and utilize subject matter experts when needed in sexual assault complaints.[38]

At a Commission roundtable about police responses to gender-based violence, Professor Isabel Grant explained that the description provided of Ms. Butlin's statement that she had acquiesced to sexual activity to ensure her safety did not meet the criteria for consent in Canadian law. She also noted that the 2015 *RCMP Sexual Assault Investigation Best Practices Guide* suggests that a woman has to communicate that she does not consent, and this is not an accurate description of the law of consent in Canada, which is based on the expression of affirmative consent to the sexual activity in question, as established by the Supreme Court of Canada in *R v Ewanchuk,* [1999] 1 SCR 330. The RCMP guide does not account for the circumstances in which no consent is obtained, for example, where there is violence or the threat of violence.

The reviewers conclude that "unfortunately it will never be known if full and comprehensive investigations had been conducted into the incidents leading up to the murder of Ms. Butlin, if investigators would have been led to a different conclusion and ultimately a different end result."[39]

On July 19, 2022, the chairperson of the Civilian Review and Complaints Commission for the RCMP announced that she had initiated a public interest investigation into the conduct of the sexual assault investigation and response to concerns about Ms. Butlin's safety. The results of this investigation have not yet been published.

In our evaluation of the RCMP response to Ms. Butlin, we are particularly struck by the fact that multiple RCMP officers reviewed her complaints and decided they did

not warrant charges. They did so based on a flawed understanding of the law of consent and a failure to appreciate the dynamics of gender-based violence such that the degree of risk to Ms. Butlin was not recognized. Multiple members did not see the violence that she reported for what it was: a sexual assault. They did not recognize the risk posed to Ms. Butlin by her proximity to a neighbour who sexually assaulted her, intimidated her, abused alcohol, and terrified his own wife. When Ms. Duggan called 911 and told the call-taker that she feared her husband was going to harm her and kill Ms. Butlin and that she thought he had obtained a gun, the attending officers did not investigate or follow up on this information; instead they charged a drunk and violent man with an impaired driving offence.

That multiple responding members and their supervisors did not recognize Ms. Butlin's and Ms. Duggan's complaints as evidence of criminal wrongdoing, warranting further investigation or requiring a safety plan, suggests that this problem is not of these particular individual officers but rather represents a systemic failure. Even when an internal review sets out nine areas for improvement and recommendations to achieve that improvement, as discussed below, the conclusions from the review were not shared with the members involved so that they could benefit from those lessons.

As Professor Grant observed, Ms. Butlin "did everything she could to use the systems in place to get her some help."[40] Those systems wholly failed her. After her repeated requests for help and protection were dismissed, Mr. Duggan murdered Ms. Butlin in her home.

Ms. Nicole Doucet

The account we supply of this case is largely based on information supplied in judicial decisions in the case of *R v Ryan,* 2010 NSSC 114; 2011 NSCA 30; 2013 SCC 3, and further details provided in a book written by Dr. Nadia Verrelli, professor of political science at Laurentian University in Ontario, and Dr. Lori Chambers, professor of gender and women's studies at Lakehead University in Ontario.[41]

Nicole Doucet was charged under her married name of Nicole Ryan with counselling an undercover RCMP officer to commit murder. The intended victim was her estranged husband, Michael Ryan. The conversations Ms. Doucet had with the RCMP officer were recorded, and she admitted to the elements of the offence. At her trial, she argued that she was entitled to be acquitted on the basis of the defence of duress.

Her case eventually went to the Supreme Court of Canada, which denied the applicability of duress to her circumstances but took the unusual step of issuing a stay of proceedings. Justice Louis LeBel and Justice Thomas Cromwell held for a majority of the court that:

> The abuse which [Ms. Doucet] suffered at the hands of Mr. Ryan took an enormous toll on her, as, no doubt, have these protracted proceedings, extending over nearly five years, in which she was acquitted at trial and successfully resisted a Crown appeal in the Court of Appeal. There is also the disquieting fact that, on the record before us, it seems that the authorities were much quicker to intervene to protect Mr. Ryan than they had been to respond to her request for help in dealing with his reign of terror over her … In all of the circumstances, it would not be fair to subject [Ms. Doucet] to another trial. In the interests of justice, a stay of proceedings is required to protect against this oppressive result.[42]

The facts that led the court to this conclusion were as follows. Ms. Doucet married Mr. Ryan in April 1992. They had one child, and were separated by 2008, when the alleged offence occurred. Mr. Ryan was violent to Ms. Doucet throughout their marriage and engaged in controlling behaviours that are characteristic of coercive control. Coercive control was discussed at length in Volume 3, Violence. A concise definition was offered by Dr. Chambers in a roundtable on police responses to intimate partner violence:

> [C]oercive control is a pattern of behaviour that develops over time, which uses isolation, intimidation, and control to keep women from being free to make decisions for themselves, to keep them tethered to men who treat them with complete and utter disrespect. It does not have to include a lot of daily violence.[43]

In abusive relationships, coercive control is significantly more strongly correlated with lethal violence than is the infliction of major physical injury.

The pattern of coercive control in Ms. Doucet's marriage included Mr. Ryan speaking to her in derogatory terms, regularly threatening violence including threatening to kill her and their child, treating Ms. Doucet as a servant, making her sign property over to him, and forcing her to engage in sexual activity. On at least three occasions, he threatened her with firearms. The trial judge in her case concluded "that Michael Ryan was a manipulative, controlling, and abusive husband, that

sought at every turn to control the actions of his wife, be they social, familial or marital."[44] However, as is relatively common among women who experience intimate partner violence, Ms. Doucet testified that she did not consider herself to be abused. Dr. Verrelli and Dr. Chambers explain:

> [S]he clearly stated in court that Ryan had "never beaten" her. [Her defence counsel Mr. Joel] Pink subtly corrected her, asking "other than putting his hands around your throat?" She responded, "He has never hit me with his fist." When asked directly whether she thought of his hands around her neck as violence, she replied no, that her definition of violence was "being pinched, beat, beaten with a fist so that it leaves bruises, cracked ribs, broken bones." Indeed, when asked by both her lawyer and the Crown if she had ever told anyone what Ryan was doing to her, she responded, "I was too embarrassed."[45]

At her trial, this evidence was contextualized with expert evidence that explained that minimization of the violence one has experienced is a well-documented coping strategy, reflecting that "people who have been traumatized don't want to think about it."[46] Another expert witness explained that women frequently don't volunteer information about sexual abuse even to a counsellor: "it's so very intrusive … the ultimate demeaning of a human being."[47]

In late 2007, Ms. Doucet separated from Mr. Ryan. Mr. Ryan was charged with uttering threats against her, but those charges were dropped. At the time he was charged, a risk assessment was conducted and the matter was determined to be high risk. Mr. Ryan's firearms were seized, and later returned. A victim services worker recommended that a panic button be issued to Ms. Doucet but police declined to do so, perceiving the threat to Ms. Doucet to be low.

Friends and relatives observed that Ms. Doucet was very anxious, upset, and increasingly unwell after the separation. A colleague who helped her move house witnessed Mr. Ryan call Ms. Doucet's cellphone 17 times in an eight-hour period, and "he did not count the house phone calls."[48] In the ensuing months, "[s]he called the RCMP on nine occasions, victim services on eleven occasions, and 911 on one occasion."[49] On each of these occasions, she registered a complaint about Mr. Ryan's behaviour and described her fear of him. The police consistently declined to take any action against Mr. Ryan, characterizing the conduct she complained of as a civil matter. This included an occasion on which police were called to Ms. Doucet's workplace because Mr. Ryan had come there. After that incident,

which was particularly unsettling because her workplace had previously been a safe haven, Ms. Doucet felt she was at an impasse: "She had attempted to use every avenue available to her to resolve the concerns she had about Mr. Ryan and, in particular, her concern that he would do harm to herself or her daughter."[50]

Because Ms. Doucet admitted the elements of the charge against her, the circumstances in which an undercover RCMP officer came to be posing as a potential hitman are not documented in the trial decision. The Nova Scotia Court of Appeal decision provides a little more information:

> It appears that, around that time, Ms. Doucet made a failed attempt to hire a killer, although again the record is not clear just exactly when this would have been. This came to the attention of the RCMP. They set up a sting operation. It was by then late March 2008 when, as the trial judge concluded, Ms. Doucet was "at her weakest". An undercover police officer called her and offered to "do the job". She took the bait.[51]

A 2013 report prepared by the Civilian Review and Complaints Commission for the RCMP concluded that the RCMP members involved in complaints made by Ms. Doucet, her family, and Mr. Ryan had followed RCMP policies and procedures and that their decision-making and investigations were reasonable.

This report has been widely criticized for the approach taken by the Civilian Review and Complaints Commission for the RCMP, with commentators claiming that the report ignored evidence that was accepted by the court in Ms. Doucet's trial, betrayed a lack of understanding of coercive control, and uncritically accepted RCMP members' accounts of their decision-making.

Dr. Verrelli and Dr. Chambers provide a lengthy analysis of the Commission for Public Complaints report in their book and in an academic article published in the *Canadian Journal of Law and Society* in 2017.

In Doucet's case, as in other instances related here, we observe a pattern of police not recognizing a perpetrator's behaviour as constituting violence sufficient to warrant police intervention, and failing to believe and act on a woman's expressed concern for her safety. In all three of these cases, concerns were expressed to police about a perpetrator's access to firearms and how this access amplified the threat presented by the perpetrator. These concerns, too, largely failed to galvanize police intervention. In all three of these cases, the low-visibility decisions made by police in response to community members' complaints would never have come to broader

public attention if subsequent events had not prompted scrutiny of police decision-making. As we explain in the next section, these patterns recur in other evaluations of police decision-making about gender-based and intimate partner violence.

Other Evidence of Everyday Problems in Canadian Policing

The environmental scan prepared by the Commission reveals patterns in the findings of past reviews of and inquiries into police practices in Canada, including repeated police failures to recognize and respond adequately to the danger presented by those men who commit gender-based violence,[52] **as well as – overwhelmingly – shortcomings in police note taking and documentation.** For example, in May 2012, a report that considered the death of Mi'kmaw woman Victoria Paul in Truro police custody identified that the need for training and the importance of note taking had been exhaustively documented in past reports, observing that "[w]hile there is a gap in training, no amount of training will compensate for a lack of judgment."[53]

We also heard that the problems documented in the Butlin independent officer review may persist. At a roundtable, Ms. Emily Stewart described the dynamic that she observes in her role as executive director at Third Place Transition House in Truro:

> [T]he word I've heard used is "ticky-tacky" scenarios where, if you've got limited time, and there's no physical evidence, there's a reluctant witness, and there's no other witnesses present, how much – as a police officer, you're using your discretion. You have to use foresight. "Is my commanding officer going to support the charges?" "Is the Crown going to support the charges?" "How far do I think this has?" "How much legs do I think this has?" when you're responding to the incident in somebody's home.
>
> Also, the pressure for statistics and how that impacts – so if you are measuring success in terms of arrest rates, you're not going to spend your time investigating cases with a low probability of arrest or conviction, which we know gender-based or intimate partner crimes are, despite that these are violent offences ...

> … I've heard from a client that her abuser said to her, in relation to this case, "You know what Junior [Mr. Duggan] did to Suzie [Ms. Butlin]? That's going to be you" – in the same community this happened. She reported it to RCMP and they said that's not a threat. And she told that to us and she didn't want us to take that any further because there's only three RCMP officers at that detachment. The next time something happens, who's going to be at her door?[54]

After this roundtable, we received a letter from counsel for the RCMP advising that the RCMP had contacted Ms. Stewart to seek more information, to "identify the file for further review and follow-up action if necessary." Ms. Stewart advised the RCMP that "it would not be good to revisit the matter as the victim has moved on, is doing well, and made it clear that she wanted nothing more done due to the initial experience she had with police."[55] Nonetheless, the RCMP conducted a review of 249 uttering threats files from the previous 18 months. Counsel for the RCMP advised the Commission that the RCMP had not identified any file that corresponded with Ms. Stewart's description, but that it is continuing its work to do so. Counsel for Transition House Association for Nova Scotia responded:

> Ms. Stewart and Third Place in Truro have had the opportunity to now review their files and we confirm the veracity of everything said by Ms. Stewart.
>
> We are disappointed that the RCMP does not keep better records.[56]

Dr. Myrna Dawson is professor and research leadership chair in the Department of Sociology and Anthropology at the University of Guelph. In a Commission roundtable, she identified the importance of grappling with why many police do not appreciate that understanding and responding effectively to intimate partner violence and sexual violence is a core police responsibility:

> [W]hy does intimacy repel law? Why is it that policing doesn't want to get engaged with intimate violence when it occurs? What is it about intimate violence that makes it seem to policing like it's something that's less serious than they want to deal with? It's something that, you know, we just want to close the door on because it's a – it's a nuisance crime.
>
> … [I]t's police who are the front-line providers in many cases, and so why do they believe, despite the fact that intimate partner violence is

> essentially the bulk of their business, why do they believe that it's something that they don't want to deal with?[57]

Answering these questions fully requires us to address police culture. As we explained in Part C, culture is an amorphous term and police culture is a challenging phenomenon to influence externally. Acknowledging this difficulty, in this Part we set out strategies that will improve police practices in the near term and will, if consistently implemented, change police culture in the longer term.

In their testimony before the Commission, Dr. JaneMaree Maher and Dr. Jude McCulloch, professors at Monash University in Australia who also prepared an expert report for the Commission, explained that taking intimate partner and gender-based violence seriously has inherent value and may also be the most promising strategy for preventing mass violence:

> [I]f we begin as a society to take gender-based violence seriously and respond to it effectively with the mechanisms that we have at hand, we have then a chance of bringing into view people whose patterns of behaviour in that context are escalating moving towards threatening other types of violence that then move on to affect others.
>
> I think one of the things we would want to say about the continuum of private and public violence is that even when the private violence doesn't come into the public sphere, it has public impacts. It impacts those around both the victim and the perpetrator. It impacts children. It impacts family members. It impacts health services. It impacts workplaces. So there is always a sense in which [ostensibly] private violence is always already having public effects that we are increasingly aware of. It seems that given the difficulty of predicting those pathways, or catching them, or recognizing them, that one of the mechanisms that we have to hand is a clearer and stronger and more solid attention to private violence as a critically important public problem.[58]

As we explain in Volume 3, Violence, Dr. Maher and Dr. McCulloch use the term "private violence" to signify violence that has traditionally been regarded as being less worthy of public and police response:

> [T]he idea of private violence, it's not just there's a dichotomy, there's a hierarchy. Definitely, public violence is saying it's more worthy of

> intervention, more worth, for example, as police and security agents see interest, than private violence, and this dichotomy has fundamentally undermined the human rights of women because most violence – most violence against women is in fact private violence. So it means that – this dichotomy means that we often turn away from, deny, and minimize private violence as less important.[59]

A core insight offered by Dr. Maher and Dr. McCulloch is that there are "intimate connections" between ostensibly private, underpoliced forms of violence such as gender-based and intimate partner violence and other forms of violence that are widely recognized as being of wider public concern, such as mass violence. Proactively "intervening earlier to stop the escalation of gender-based violence" must therefore be a core police strategy for preventing violence more generally.[60] We can see these broader impacts, and the pattern of escalation, in the perpetrator's behaviour before the mass casualty and also in the Butlin and Doucet examples. Recognizing these connections may, in turn, help counter the police tendency to turn away from women's accounts of gender-based and intimate partner violence.

As we explained in Volume 3, Violence, seeing "private" and "public" violence as two distinct phenomena is incorrect and problematic. Indeed, having noted that the deep and multifaceted connections between gender-based violence and the perpetrator's actions on April 18 and 19, 2020, are clearly established, we found that the pattern of escalation from gender-based violence to mass casualties is well documented. This pattern is often unseen, unstudied, overlooked, or ignored. We found that, although every incidence of gender-based or family violence will not result in a mass casualty, the first step in prevention is in recognizing the danger of escalation inherent in all forms of violence.

In the next chapter, we identify five strategies for building police capacity to make better decisions in low-visibility circumstances, particularly in areas where problems with how police exercise their discretion have been well-documented. These strategies will ensure that police are better equipped to recognize and respond effectively to intimate partner and gender-based violence and that they can work respectfully with communities who have been overpoliced and underprotected by police. Implementing these strategies will change police culture over time, but each of them will also improve the quality of police services in the near term.

CHAPTER 13

Five Strategies for Improving Everyday Policing

CHAPTER 13 Five Strategies for Improving Everyday Policing

The problems we have documented in this Report are longstanding and far from simple. However, everyday policing practices can be improved by implementing a coordinated set of fundamental strategies. Each of these strategies is designed to foster better decision-making in low-visibility situations. As we set out in the introduction to this Part D, the strategies we suggest relate to how police students and police recruits are selected; police education; note taking and record keeping; front-line supervision and feedback; and community-engaged everyday policing. In this chapter, we look at each in turn.

Selecting Police Students and Police Recruits

How should prospective entrants to police education courses be recruited and selected? What criteria should police services use when they, in turn, recruit members? In Part C, we quote Dr. Kimmo Himberg, the former rector of the Finnish Police University College, who explained that his college selects police students carefully for character traits considered suitable to a career in policing. In Canada, there are many police services (in contrast to Finland, which has a single police service). Canadian police services have a further opportunity, at the time of recruiting members or employees, to select on the basis of desired characteristics. We turn to the discussion of police education in the next section, but here we discuss what we learned about the value of adopting a careful approach to recruitment. Our discussion applies both to selecting students into a police education program and to selecting members into a police service.

Expert report writer Dr. Bethan Loftus, senior lecturer in criminology and criminal justice at Bangor University in Wales, explains in her report, "Police Culture: Origins, Features, and Reforms":

> Altering recruitment patterns cannot be the definitive answer to changing police culture, but such efforts have the potential to break down the relative uniformity of the traditional police force composition. Officers from socially, culturally, and educationally diverse backgrounds may be less susceptible to police acculturation processes, pursue less confrontational approaches during interactions, and buy into victim-centred and community-focused philosophies.[1]

In a roundtable on police accountability, Dr. Loftus emphasized that recruiting from under-represented backgrounds will not succeed if other problems within police culture have not been proactively addressed: "[T]here is a danger, of course," in that police agencies should not recruit "in any kind of tokenistic way that can have quite harmful effects for officers from minority previously excluded backgrounds who then find themselves in an organization where there is still, you know, some deep-seated resentment and the backlash towards that."[2]

We endorse efforts to increase the recruitment of police students from backgrounds that, historically, have been marginalized within policing.[3] **These candidates should be financially and culturally supported to obtain a police education. However, we stress that Canadian police services will continue to find it difficult to attract candidates from these backgrounds if they cannot demonstrate to the community that they are transforming their educational approaches and their existing cultures**. Indeed, we believe that police services that are taking meaningful steps to acknowledge and address problems of misogyny, racism, and other inegalitarian beliefs and approaches will have a significant advantage in their capacity to attract and retain recruits who will do their work in a way that advances the eight principles of policing set out by Dr. Ian Loader, professor of criminology at the University of Oxford (see Chapter 9).

Processes for recruitment to police education and, after graduation, for recruitment to police services should be research based and address the following qualities for each candidate:

- motivation for seeking a career in policing;

- demonstrated potential to take initiative and exercise considered judgment without supervision;
- interpersonal skills, including when dealing with individuals and communities from different backgrounds; and
- understanding of and demonstrated commitment to promoting substantive equality and social cohesion.

Dr. Himberg explained in our roundtable on critical incident preparedness that the Finnish approach is to be "extremely careful in selecting our students through several psychological test sets and interviews."[4] The Finnish Police University College seeks to screen out "Rambos, Rockys" in favour of people who possess characteristics on which a police education that emphasizes the ethical responsibilities of policing can build. Dr. Himberg emphasized that it is also possible to be "research based" in terms of recruitment.

Recruitment strategies are long-term approaches to achieving cultural change within an organization, and they will fail if the organizational culture is not open to adapting to the changing attitudes and approaches that more diverse recruits can offer. The risk of a poorly coordinated implementation strategy is that police organizations will recruit candidates who bring new skills, perspectives, and backgrounds to policing, but that these recruits will not be institutionally valued or given opportunities to work to the strengths for which they were recruited. This challenge was articulated by Dr. Barbara Perry, the director of the Centre on Hate, Bias, and Extremism at Ontario Tech University, in a roundtable exploring the connections between mass casualties and various forms of gender-based violence:

> [W]e can do all the training we want, we can have the best policies in place, but there is still a culture of misogyny, there's still a culture of racism in policing … it is about shifting the culture, and some of that is about bringing different people into the – into the organizations, but it's a chicken and egg. I mean, how do you bring people into organizations where they know they're going to be marginalized, where they know perhaps they're going to be targets of assault and victimization?[5]

Recruitment strategies will fail if candidates and employees from historically underrepresented backgrounds perceive they cannot reach their full potential within police services. They must have access to mentoring and development opportunities and be able to see themselves in every corner of the police

organization – from front-line, to specialized, to leadership positions. In other words, the goal of inclusion involves more than seeing yourself in an institution. It is enriching that institution by introducing and acting on perspectives that have historically been marginalized. If Canadian police leaders are sincerely committed to addressing the diversity of police agencies and improving the quality of police recruits, these factors will need to be acknowledged and proactively managed.

The value of embracing a recruitment strategy is that, over the long term, it will enhance the effectiveness of front-line policing and rebuild community trust in police. To achieve that goal, however, the strategy must recruit police candidates who have the capacity to exercise mature judgment and to pursue the democratic principles of policing in the course of their daily, low-visibility decision-making.

LESSONS LEARNED

Research-based approaches for best practices in police recruitment exist and have been successfully implemented in other jurisdictions.

Recruitment strategies designed to increase the number of police officers from under-represented backgrounds will fail if they are not accompanied by educational and cultural change in Canadian policing.

Recommendation P.69

RECRUITMENT

The Commission recommends that

(a) Canadian police education programs should adopt research-based approaches to student admission processes, based on a clear understanding of the personal characteristics that form the basis for effective democratic policing.

(b) Canadian police agencies should adopt research-based approaches to police recruitment, based on a clear understanding of the personal characteristics that form the basis for effective democratic policing.

(c) Canadian police agencies should establish a comprehensive strategy for recruiting and retaining employees who are presently underrepresented in Canadian policing.

IMPLEMENTATION POINTS

- This strategy should include measures that are designed to support such recruits and allow them to work to the strengths for which they are recruited.
- Police agencies should change established practices and procedures where necessary to establish a safe and welcoming workplace for recruits from historically under-represented backgrounds.

Police Education

In Part C of this volume, we recommend that the federal, provincial, and territorial governments should work together to establish police education degree programs on several campuses across Canada. We suggest that these programs should be modelled on the Finnish Police University College, with adaptation as necessary to reflect Canada's legal and constitutional structure of policing and higher education. We also suggest that successful completion of this degree program become a minimum requirement for police recruits to Canadian police agencies, replacing or absorbing existing police training academies such as Depot – the RCMP Academy in Regina – and the Atlantic Police Academy.

This new degree program will entail a significant investment by the federal, provincial, and territorial governments and by police students as well. It will also require Canadian police agencies to embrace change. This model means police agencies will not only influence police education and necessarily continue to be involved with it but will share the responsibility with institutions of higher education that can bring both research expertise and expertise in education to the table. We encourage Canadian police agencies to follow the example set by the Finnish police and to collaborate with universities and researchers to evaluate and improve their own policing practices.

Dr. Himberg observed in the roundtable that investing in the quality of police education is "a big investment. But on the other hand, we are educating people who will work as police officers for 30, 40, 45 years, perhaps. The cost of education is marginal in comparison to the cost of the officer as a whole. Pedagogical and educational expertise in police education [is] essentially important."[6]

In Part C, we cite use of force training as an example to explain why it is necessary to transform Canadian approaches to police education. Our discussion in Chapter 12 of the cases involving Susan (Susie) Butlin and Nicole Doucet, and other evidence we heard in our process, provide further illustration of why there is a pressing need to improve police education in Canada.

A noteworthy feature of the Butlin case is that all the front-line RCMP members and supervisors who were involved with Ms. Butlin's complaint demonstrated a lack of understanding of the Canadian law regarding sexual assault, and in particular the principles of consent to sexual activity. In a roundtable on police and institutional responses to sexual and gender-based violence, we heard from Sunny Marriner the national project lead of the Improving Institutional Accountability Project. This project, which is currently operating in 28 communities across five Canadian provinces, brings subject matter experts together to review files in which police have decided not to lay charges after receiving a complaint of sexual assault. Ms. Mariner explained that the problems identified in the Butlin example are symptomatic of a pattern:

> [P]olice assessments of credibility and whether or not consent were present are deeply inconsistent across both police services and also across the country. So nationally from coast to coast to coast, you see widely disparate determinations of whether or not consent is present and whether or not an account is credible.
>
> ...
>
> One of the things that we see across reviews across the country is that there is a disturbing range in understanding of the actual law of consent. We frequently, to again hearken back to what [Professor] Isabel [Grant] was just saying, we frequently see officers saying, "Well, you didn't say no, so it's not sexual assault," or "he didn't know that you weren't consenting, so it's not sexual assault," again, not understanding the affirmative consent law in Canada. And so even at the baseline of understanding what is consent, we see issues there.

> And connected to that, we also do sometimes see issues of what I would say is not just a lack of knowledge of consent law, but in fact of disagreement, an active disagreement with consent law, and thus, even if the law is understood, it's not necessarily agreed with by the institution of policing itself or the individual officer, and thus, their interpretation of what is required for sufficient evidence, the standard becomes very, very high.[7]

Similarly, we heard from expert report writer Dr. Carmen Gill, a professor of sociology at the University of New Brunswick, at the roundtable on police and institutional responses to intimate partner and family violence that police often fail to recognize coercive control because they are accustomed to looking for evidence of individual criminal acts rather than patterns of behaviour:

> When we talk about IPV [intimate partner violence] coercive control, we're not talking about an incident. The police officer shows up, he's responding, she's responding to an incident. So when they come to a place, a victim that has to demonstrate that she's a true victim, who is not necessarily reporting an incident but a pattern that she's caught in, how do you do this? And the police officer's narrow in his way of approaching this particular issue because they're asked to look [for] an incident, they're not asked to look for something else. We're not asking them to look at the complexity of the issue.[8]

Dr. Gill specifically connected these problems to the relative lack of education that most police receive about intimate partner violence and patterns of violence in relationships.

Dr. Lori Chambers, a professor in the Department of Gender and Women's Studies at Lakehead University, echoed this point, explaining that for police, "it's really not about assessing process, observing changes over time in a relationship, or talking to women about wider patterns of control."[9] Dr. Patrina Duhaney, a professor in the Faculty of Social Work at the University of Calgary, emphasized that these challenges are even more pronounced for Black women who experience violence:

> [O]ftentimes police do not understand the complexities of violence in Black women's lives. … [O]fficers may also endorse these derogatory stereotypes and may construct Black women, for instance, as argumentative, aggressive, violent, who instigate a fight or are more likely to provoke their partners or emasculate Black men. And so these women run

> the risk of their victimization being undermined and being classified as an accomplice.[10]

As the RCMP independent officer review of police responses to Ms. Butlin recognizes, some complaints that front-line police encounter engage relatively complex areas of law. They also require that members recognize the effects of trauma on witnesses and know how to work with traumatized complainants (see Chapter 12). In a roundtable on the structure of policing in Nova Scotia, Kristina Fifield, a trauma therapist with the Avalon Sexual Assault Centre in Halifax, explained the importance of police recognizing trauma reactions – both their own and those of others:

> [W]hen police are responding, or any individual is responding to an individual that has a history of trauma, where violence has been used against them, they need to understand what that looks like. And that look can look different for different individuals or individuals from different communities. And making sure that when police or RCMP are responding that they're not further escalating that situation and sending a person further outside of their window of tolerance, or for officers who are responding making sure that they're not outside of their window of tolerance when they're responding to individuals. And I think that's an important conversation that we often don't talk enough about in regards to understanding trauma.[11]

Outside Quebec, the present Canadian standard is for police to receive basic training on all aspects of policing in six months, followed by six months of field coaching of dwindling intensity. This approach to police learning is inadequate to equip front-line police with the nuanced skills they require to be able to respond effectively to complaints such as those from as Ms. Butlin or Ms. Doucet (see Chapter 12). Despite stated opportunities for ongoing police education after basic training, the Butlin review shows that even supervisors and more experienced officers are not always equipped to recognize when they may require subject matter expertise to assist them to exercise legitimate discretion. Far more often, decisions made by front-line police officers about whether a given complaint amounts to criminal behaviour, presents a serious risk to victim safety, or warrants further investigation are low visibility and may never come to the attention of supervisors. These decisions are even less likely to be reviewed by external oversight agencies.

As we document in Volume 3, Violence, shortcomings in police practice are also evident in the police response to complaints made about the perpetrator before the mass casualty. Those who sought to report the perpetrator's violence were

often at best misunderstood by police who, at a minimum, did not possess the training or spend the time necessary to understand the nature of their concerns. The perpetrator was quick to retaliate against those who reported him, including by lodging police complaints against them in turn or, in the case of his neighbour Brenda Forbes, by embarking on a campaign of criminal harassment. While some police made greater efforts to investigate complaints about the perpetrator than others, neither RCMP members nor the Halifax Regional Police officers who dealt with him fully recognized or countered his strategies to deflect police attention.

In sum, we agree with Dr. Himberg that "modern policing as a profession is such a complicated spectrum of skills and knowledge needs that we need to have an extensive education which combines theoretical and practical aspects" in order to equip police to do their work well.[12] This education must be built on an ethical and legal foundation that, among other things, identifies and counters myths and stereotypes about gender-based and intimate partner violence and equips police students with an understanding of structural and institutional racism.

In Quebec, most police candidates complete a three-year bachelor degree in public security at an accredited institution before completing an intensive fifteen-week practical program at the École nationale de police du Québec. The criteria for admission to the academic component of this program emphasize the candidate's school record but do not incorporate the holistic assessment of suitability that we contemplate in the previous section. Stakeholders consulted in a review of Quebec police services completed in May 2021 indicated that a more holistic approach would be desirable, and the report makes a recommendation to that effect. However, the Quebec program already offers a more comprehensive education in dealing well with a range of social problems and a diverse community than those in other provinces, devoting 480 learning hours to these topics. Even so, the stakeholders concluded that more training, including more practical training, is necessary. This report is one of the reasons why we favour the Finnish model, which integrates practical training throughout the three-year program of study, over the Quebec model.

Quebec has also designed a specific program for Indigenous police candidates and others from historically under-represented backgrounds and identities, with a shorter study period and with financial support for the training component at the École nationale de police du Québec. However, the stakeholders consulted for the 2021 report expressed concern that the material omitted from this shorter program contains important educational material on Canadian law, immigration, and

preventive and community-based policing. The Quebec report also states that the present approach has had some success in increasing the number of women police candidates in Quebec, but less success among police candidates who are racialized. The report identifies financial barriers as a significant reason for the lack of success in recruiting a student pool that is more representative of Quebec's diversity and offers a range of possible strategies for addressing this barrier.

Completion of the Quebec program entitles police candidates to a licence to work as a police officer in Quebec. A 2019 green paper prepared by the Quebec government identifies the benefits of this model, including the ways in which the educational components of the program are informed by the findings of past reviews of police practice and by the needs of police agencies in Quebec. This review identifies that some stakeholders in the police community in Quebec have advocated for shortening the duration of training, but concludes: "Calls to reduce the length of training are seemingly at odds with numerous recommendations, from coroners' inquests and public inquiries, to extend training and add new themes. Clearly this discrepancy will need to be considered as we reflect further on the topic." (as translated)[13]

The Quebec experience provides helpful guidance for the implementation of an appropriate model for police education in the rest of Canada. Based on the 2021 Quebec report, the 2019 green paper, and the evidence we received, we favour making a three-year degree program a standard requirement for all police recruits. Financial and cultural support should be provided to police students from underrepresented backgrounds and identities.

Moving to a standard of three years of police education in Canada will allow universities to work with police agencies and subject matter experts to ensure that police recruits are better equipped at the time of graduation to do their work in areas where the police currently perform poorly, including the investigation of sexual assault complaints; recognizing and responding to gender-based and intimate partner violence including coercive control, criminal harassment, uttering threats, and hate-motivated crimes; and recognizing the effects of trauma both in themselves and on those with whom they deal. We encourage police education programs to employ subject matter experts who employ research-based approaches to design and deliver these aspects of police education.

LESSON LEARNED

The existing Canadian standard of police training outside Quebec is inadequate to equip police for the important work they do and for the increasingly complex social, legal, and technological environment in which they work. The shortcomings produced by this approach have a disproportionate adverse impact on those who have historically been underserved by police. A three-year police education program in which a research-based curriculum both precedes and undergirds practical training is necessary to equip front-line police officers to exercise legitimate discretion.

Recommendation P.70

CANADIAN POLICE EDUCATION

The Commission recommends that

(a) All Canadian governments and police agencies should, by 2032, adopt a three-year police education degree as the minimum standard for police education.

(b) Police education programs should employ subject matter experts who use research-based approaches to design and deliver curriculum, particularly in areas where police services currently underperform.

(c) Police education programs should offer financial support to Indigenous and racialized students and other students from backgrounds or identities that have historically been under-represented in Canadian police services. Financial means should not be a barrier to obtaining a police education.

Note Taking

In Chapter 12, we explain that the RCMP's independent officer review of Ms. Butlin's complaints observed deficiencies in note taking and documentation. We also state that such findings are ubiquitous in Canadian reviews of police practices.

Note taking is an essential component of everyday policing and fundamental to the role of police in the administration of justice. A national RCMP policy describes the role of notes in refreshing memory, justifying decisions made, and recording evidence. It explains further that "Well-documented notebook entries lend credibility to testimony and can substantiate information years after the original entry was made. Inadequate and inaccurate entries in a notebook can compromise an investigation and subsequent criminal, civil, and/or administrative proceedings."[14]

In addition to direction on the required ink colour, using a "Z" line for unused space, and the proper way to delete an entry, the policy instructs members to make their written or electronic notes as soon as possible so they are an accurate account of "observations made and actions taken during the course of their duties:"[15]

> 3. 1. Investigator's notes should thoroughly describe the details of the occurrence and answer: who, what, when, where, why, and how.
> 3. 2. Notes should contain professional language, unless documenting verbatim comments.
> 3. 3. Notes should be factual and descriptive enough to explain decisions made.
> 3. 4. Sketches and measurements enhance the quality of notes and should be included where practicable.[16]

The policy states that the "Contents of forms, either written or electronic, which are not made contemporaneously to an event, are not considered notes and are not a substitute for an investigator's notebook."[17] During her testimony, Commr. Brenda Lucki was asked about the risks of purging electronic information. She responded: "And that's why we're not asking them to do one or the other. Their notebook is still their primary source."[18]

Documents produced during our process suggest that problems documented in past reviews remain widespread. A 2016 Unit Level Quality Assurance audit conducted by the RCMP of members' note-taking practices in Cumberland County

found that the requirement for regular supervisor review of notebooks was being complied with in only one of five detachments and that member notebooks did not contain sufficient detail to meet RCMP policy standards. An example provided in the audit report is that "anything said by any suspect or witness, word-for-word if possible, was not a regular entry in note books."[19] In 2020, RCMP S/Sgt. Darren Waidson, district commander for Victoria County, NS, identified in a Northeast Nova District performance plan that "officer notes continue to be a concern throughout the force. There have been recent strategies developed to help augment note taking, and ensure consistency in reporting. A big piece of this is supervision, and I will ensure that NCOs are aware of the needs to review member notes and general reports."[20]

RCMP national policy sections 4.2 and 4.3 direct supervisors and unit commanders to monitor members' notes. Specifically, the supervisor is responsible for inspecting members' notebooks and/or electronic notes regularly and documenting them biannually during the member's performance assessment review. Corrective action for any gaps in note taking can be resolved through "verbal guidance and/or written direction." If deemed necessary, the supervisor will note the corrective action in a performance log.[21] Supervisors are directed to make notes of their review of a member's notebook in their own notebooks and, when reviewing electronic notes, to submit a supplementary report.

Problems with RCMP note taking were also evident in our process. The Commission reviewed notes made by new and experienced members – front-line, supervisory, and senior management alike – who responded to the mass casualty or took action in the days and weeks after April 18 and 19, 2020. The Commission scheduled several days of testimony, in part because police officers' notes were incomplete, illegible, missing, or simply did not articulate their observations, decisions, and actions as required by national policy. As the Butlin independent officer review acknowledges, "Without effective documentation it is difficult, if not impossible, to determine if appropriate actions were taken."[22]

For example, Cpl. Kenda Sutherland, Cst. Karl MacIsaac, and Cst. Troy Maxwell responded at various times to the complaint Ms. Forbes made against the perpetrator in 2013. Of these members, only Cst. Maxwell could locate any notes from his work on this complaint. These notes contained little information about Ms. Forbes's conversation with RCMP members and omitted information that Cst. Maxwell later recounted about this conversation. This unrecorded information was, in turn, at odds with Ms. Forbes's recollection. We address the substantive aspects of this

complaint in Volume 3, Violence. For now, we acknowledge that Cst. Maxwell did at least take some notes, but his colleagues evidently retained no notes at all. Similarly, Cst. Gregory (Greg) Wiley was unable to produce any notes with respect to his interactions with the perpetrator, most notably after he was called to assist the Halifax Regional Police with a firearms complaint in 2010. In another instance, neither the RCMP nor a former RCMP member who is now in a legal dispute with the RCMP produced that member's notes, which may have shed light on how the RCMP responded to the 2011 CISNS Bulletin at the time when it was issued. This bulletin warned that the perpetrator had firearms and had expressed a desire to "kill a cop." It warned police to "[u]se extreme caution" when dealing with the perpetrator.

Similarly, we explain in Volume 3 that Cst. Richard (Rick) Schnare and Cst. Patrick McNeil attended Portapique in response to a 911 call placed by DD in August 2019. Only Cst. McNeil produced notes from the response to that call. This incident involved DD, EE, and II, whose names have been anonymized by the Commission. These notes contain only DD's name, address, and telephone number and EE's name and telephone number, with no details recorded about the nature of the complaint, anything said by those with whom the members interacted, or any actions taken by the members. This incident is important because II told the Commission, and DD confirmed, that II attempted to complain to the responding members that the perpetrator had sexually assaulted her. DD advised police that II was "just drunk," and officers helped DD to put II into a car. No further investigation ensued. DD, EE, and II had been in the perpetrator's warehouse that night and had observed the perpetrator's replica RCMP cruiser. Had members followed up with II that night or afterward, they may have learned this information.

Counsel for the RCMP submitted to us that the Commission cannot make certain factual findings, including a finding that a warrant to search the perpetrator's properties should have been pursued after the 2011 CISNS Bulletin or that a warrant should have been pursued after Ms. Duggan's 911 call about her husband's violent behaviour and possible acquisition of a firearm. However, it is not necessary for us to make such factual findings to determine that record-keeping practices and information sharing among Nova Scotia police agencies were deficient and that the police should have exercised their discretion to conduct further investigations and ensure complainants' safety. When police receive a complaint, they should document the information they hear as fully as possible, even if they are of the view that no charges are warranted at that time. They should also consider what investigative steps may be warranted by way of follow up. One key purpose

of maintaining such documentation is to ensure that an official record is created, so that patterns may be identified, and another is to facilitate supervisor review of member decision-making. Careful record keeping also assists with determining whether other steps are necessary to ensure the safety of the complainant. Careful notes should always be taken, whether or not the police officer believes that a complaint reveals a chargeable offence.

S/Sgt. Waidson's acknowledgement of the link between the quality of note taking and effective front-line supervision is significant. **Note taking is the single front-line member practice that has the greatest potential to enable effective supervision and, in turn, to facilitate democratic accountability for low-visibility decision-making. The quality of front-line members' note-taking practices and the quality of supervision of note-taking practices are both important markers of the extent to which a police agency is committed to effective everyday policing.**

This point has been made repeatedly over many years of external reviews of Canadian policing. For example, in 1991, the Aboriginal Justice Inquiry made the following findings and recommendation with regard to the Winnipeg Police Service:

> Some surprising views emerged when we were considering the issue of notebooks. Apparently, the Winnipeg Police Association took the position that the notebooks are and remain the property of individual officers. The Chief of Police felt that the books are the property of the police department. We agree with the Chief. But we believe that despite whoever "owns" the books or the notes, procedures have to be put in place that will restore the confidence of the public and the judiciary in the integrity of notebooks and note taking.
>
> The Toronto Police Department employs much more stringent rules on the use of notebooks than its Winnipeg counterpart. Every notebook bears the officer's name and badge number, the date the book was started, and the date it was completed. Each notebook and all the pages in it are numbered.
>
> When officers come on duty they pick up their notebooks from their pigeonholes along with their weapons. Notes that are made must be original and not transferred from other sources such as scratch pads. All entries into the notebooks must be in black pen. No erasures are allowed. If a mistake is made the officer must use one strikethrough line, initial the

> error and add the correction. No blank spaces, lines or pages are permitted. A notebook must be completed before a new one is started.
>
> When officers go off duty they note the time in their books, sign the books and turn them in to the staff sergeant, who reviews them, countersigns them and returns them to the officers' pigeonholes. All notebooks stay in the detachment where officers are stationed. If officers are transferred to another district, their notebooks go with them. Upon retirement the notebooks remain the property of the department.
>
> ...
>
> **Recommendations:**
>
> Notebook management practices similar to those used in Toronto be adopted by the Winnipeg Police Department.[23]

The Civilian Review and Complaints Commission for the RCMP also flagged shortcomings in RCMP members' note-taking practices in its 2020 review of the RCMP's response to the death of Colten Boushie, a Cree man who was killed by Gerald Stanley on the latter's Saskatchewan farm in August 2019. In this report, the commission identified the need to "implement training and supervisory strategies to ensure all members take complete, accurate and comprehensive notes."[24]

Commr. Lucki was asked about this recommendation when she testified before the Mass Casualty Commission. She acknowledged that "notetaking is always an issue."[25] When Participant counsel asked why notes were always a problem given that they are so fundamental, Commr. Lucki observed that "you only need to testify in court once and then you will honestly understand the importance of your notebook."[26] She also explained that, in her experience, the quality of member note taking tends to wax and wane depending on how much institutional emphasis is placed on this skill:

> [I]t's not a new issue, and it gets better when it's reviewed, and then it's left, and it's unreviewed for a while, and then it starts to drop, and then it's reviewed and it gets better. You know, it's one of those activities that you have to keep on top of it at all times. ... Early on, obviously it's very important, we stress it in the training academy, the notebooks are reviewed constantly. And we stress that importance. And they're – you know, they're provided feedback on good notes, poor notes. And then

> they get so busy that it's one of the first things, for some reason, in some cases, to drop by the wayside. Or they still do notes, but they might not be sufficient enough.[27]

Commr. Lucki acknowledged that the RCMP practice of supervisor verification of member notebooks had not proven an effective safeguard, emphasizing that much is asked of supervisors: "[W]e ask a thousand things from supervisors and notebooks are but one."[28]

Ms. Michelaine Lahaie, chairperson of the Civilian Review and Complaints Commission, stated that her agency continues to observe problems with RCMP member note taking. In a roundtable on police oversight, supervision, and accountability, she described its experiences with the quality of RCMP members' notes:

> One of the pieces that we are often noting as well is a lack of documentation from the officers that speaks to why they made the decisions that they made. And this is a common piece within our findings and recommendations, is the fact that the reports that could be – where discretion was exercised often don't speak to the reason why the decisions were made. And we find that as well in police notes. [29]

The RCMP's national policy explains that a member's notebook is the property of the RCMP and requires members to secure them safely. Furthermore, the policy directs members to return their notebooks to the unit commander of their last posting on separation from the RCMP. As mentioned, in several cases members could not locate their notes. Some admitted to retaining their completed notebooks at their homes. Commr. Lucki also testified to keeping her notebooks at home.

MAIN FINDING

RCMP policy and everyday practices with respect to member note-taking practices and supervision of member notes are deficient. The national note-taking policy is not adhered to, including with respect to custody of the notebooks, and there is no consistent supervisory practice of monitoring the quality and content of member notes. Further, there is no daily practice of securing the notebooks at detachments.

For this reason, courts, tribunals, and the public need to be aware that simply because something is not reflected in a police officer's notes does not mean it did not happen. Police notes can serve only as a record of what police officers choose to include and how well they capture the information. The notes should not be understood as comprehensive. Courts, tribunals, and the public should exercise caution in drawing inferences from an absence of RCMP members' notes or omissions in notes taken.

LESSONS LEARNED

Member notebooks are the primary record of police officers' daily activities and decision-making.

Note taking is a crucial means by which low-visibility decision-making can be supervised and democratic policing principles can be secured. Proper supervision of this basic aspect of policing – note taking – is also an important internal accountability mechanism. Such supervision includes file review and follow up where gaps are identified in note taking and investigation. This supervision is not for punitive reasons; it is to facilitate learning by front-line officers and to ensure that front-line members are addressing the needs of the communities they serve. Regular review also ensures that supervisors gain insights into a member's judgment and can identify areas and act on areas for improvement.

Recommendation P.71

NOTE TAKING

The Commission recommends that

(a) The RCMP, following the recommendation made by the Civilian Review and Complaints Commission, should implement training and supervisory strategies to ensure that all members take complete, accurate, and comprehensive notes.

(b) The RCMP should develop an effective asset management process to retain, identify, store, and retrieve the completed notebooks of its members.

(c) Canadian police agencies should evaluate front-line supervisors' oversight of front-line members' note taking as one criterion by which their performance is assessed.

(d) Canadian police education programs should integrate effective note-taking practices into every aspect of their curriculum – for example, by incorporating note-taking skills and assessment into substantive assignments.

IMPLEMENTATION POINTS

- All Canadian police agencies should adopt the practice of requiring front-line members to provide their notebooks to their supervisor at the end of each shift for review and countersigning.
- Where necessary, electronic alternatives to these supervisory practices (e.g., scanning notebook pages for review and approval by a remotely located supervisor) can be adopted.
- The quality of an agency's note-taking practices should be assessed both by compliance with notebook review policies and by the quality of members' note taking.
- Police notebooks should be stored in police detachments between shifts.
- When members are transferred, resign, or retire, their notebooks should remain at their detachment.
- Canadian police agencies should explore the potential for transitioning to electronic note taking in light of available technologies such as cellphone voice recognition note-taking ability and the increased use of body-worn cameras. Regardless of the platform, the fundamentals of good note taking should be present, including the essential requirement of being able to ensure the integrity of records taken contemporaneously with the events they recount.

Front-Line Supervision and Feedback

Police supervisors, from corporals to the commissioner, have many responsibilities, the most basic of which is to ensure that their team members perform their necessary work. To be effective, supervisors need to know and apply policy, rules, legislation, and case law and ensure that their teams do the same. Supervisors must be technically competent, but this quality is insufficient on its own. Supervision is more than an administrative exercise. Effective supervisors need to be skilled people managers, driving desired behaviours by shaping their members' experiences through the guidance they dispense. Supervisors at all ranks need to influence workplace climate positively and set the tone for their teams.

In 2013, the Australian Army faced a sexual harassment scandal involving more than one hundred male members who shared demeaning videos and photographs of women and made degrading comments about them. Lt.-Gen. David Morrison, who was then chief of the army and the Australian of the Year in 2016, spoke to his organization about his expectations of their role in confronting this unacceptable behaviour. In his address, he lauded the contributions of female officers and soldiers, and he called on everyone to have the moral courage to address the degradation of colleagues. He stressed the additional responsibility of those in leadership positions to address behaviour contrary to the values of the Australian Army: "The standard you walk past is the standard you accept – that goes for all of us, but especially those who, by their rank, have a leadership role."[30]

While all supervisory ranks are responsible for organizational performance, front-line supervisors are arguably the most important determinants of how front-line policing operates. They are closest to those policing our communities, most likely to observe behaviour that is at odds with the dignity of community members, and well situated to influence the discretionary actions of their teams. In short, front-line supervisors are in the best position to safeguard the quality of everyday policing. The role of the front-line supervisor is especially important for police agencies, such as the RCMP, that deploy relatively inexperienced members in small detachments far removed from police headquarters and senior management.

One tool that may be used by front-line supervisors is a roll call or briefing at the beginning of a shift. During these shift meetings, supervisors inspect their teams' equipment, assess their physical condition (often referred to as "fitness for duty"),

assign tasks, and discuss job-specific information about ongoing happenings, changes in legislation, or messages from upper management. When done well, these shift meetings can resemble rounds, a process used by the medical profession to discuss patient conditions and offer opinions about possible treatment or care. Shift meetings offer opportunities for peer feedback, the reinforcement of organizational expectations, and ongoing learning.

Front-line supervisors are the primary means by which feedback can be offered to front-line police about how they do their work. It is essential that supervisors be equipped to exercise independent judgment about front-line members' work. In general terms, we observed that the independent guidance of front-line supervisors was relatively absent from the everyday work of RCMP members, even those who are inexperienced. This overall pattern was apparent with respect to the lack of scene supervision in Portapique during the mass casualty of April 2020 (see Part A), but it was also evident in other contexts.

Perhaps the most striking example of the RCMP's failure to make institutional arrangements to supervise and give feedback to members arises from the independent officer review of the Butlin case. As our account in Chapter 12 suggests, this review was a substantive exercise, entailing a careful assessment of work done by several members in Colchester County. The report identifies significant areas for improvement: a misapprehension of the law of consent; failures to take appropriate investigative steps; and a failure to seek advice from subject matter experts, for example. These matters are described in the report as a "performance gap."[31]

Three of the members involved in the Butlin case – Cst. Stuart Beselt, Cst. Rodney MacDonald, and Cst. Wiley – also participated in our proceedings, either because they had dealt with the perpetrator in the years before the mass casualty or because they were involved in the critical incident response of April 18 and 19, 2020. We asked these three front-line members whether they had received a copy of the report of the independent officer review of the Butlin case or any feedback or further training on the basis of their work on the Butlin file. All three told us they had not. We also asked S/Sgt. Allan (Al) Carroll, who was district commander of Colchester County at the relevant times, whether he had received a copy of the report or participated in any debriefing or discussion about it. He had not, nor was he aware of which members were named in the report.

The RCMP's failure to close the supervisory and feedback loop on the Butlin independent officer review is a missed opportunity to address gaps in member knowledge and to strengthen internal learning processes. The RCMP went to the

trouble of assigning three senior members to conduct a detailed review of member work. The resultant report helpfully identified significant areas for improvement in a tone that is notably careful to avoid assigning individual blame for the performance gap it identified. The failure to share this report with the members whose work was reviewed, to counsel them about how to improve their response on future occasions, to share it with their district commander so that such steps could be taken, or seemingly to take any other action in response to the findings of the report reflects a broader problem with the RCMP's approach to feedback and member learning. Even when a member has been transferred to another division or role, as Cst. Wiley was, it is still important to inform the member about the content of the review, if only to ensure that a culture of learning and accountability is promoted within the RCMP. **Overall, this and other evidence about a lack of everyday supervision leads us to conclude that the RCMP has not established the front-line supervisory structures and practices that encourage general duty members to cultivate sound decision-making skills in low-visibility aspects of their work.**

MAIN FINDING

The RCMP does not have an effective system of front-line supervision in place for general duty members in H Division. This gap deprives general duty members of day-to-day feedback about their performance, including how they exercise discretion.

LESSON LEARNED

Front-line supervision and the provision of regular feedback to front-line members are essential components of effective everyday policing practices in order to promote a culture of good judgment, accountability, and taking institutional responsibility for member learning.

Recommendation P.72

SUPERVISION

The Commission recommends that

(a) The RCMP should review the structure of contract policing services delivered in H Division to ensure that every general duty member receives routine and effective supervision, including regular feedback on the quality of low-visibility decision-making.

(b) Shift meetings should become a standard practice at the beginning of every general duty shift in RCMP contract policing. Supervisors should receive training in how to run an effective shift meeting.

IMPLEMENTATION POINT

If the structures we have identified as problematic in H Division also exist in other RCMP divisions, this recommendation should be followed in those divisions too.

Community-Engaged Everyday Policing

In Volume 4, Community, we discuss the practice of community-based policing and identify some concerns about how it has been implemented in Canada. **While community-based policing has not realized the benefits that were optimistically claimed during its heyday, the fundamental principle that community members can and should be involved with everyday policing remains sound.**

The research literature identifies a range of reasons for past failures of community-based policing. Not the least of these failures is that this approach sometimes became an exercise in paying lip service to community involvement by

strengthening ties with those community members who are already receiving the greatest benefit of police services, at the expense of those who have historically been overpoliced and underserved by police. The construction of community advisory groups is one mechanism by which this appearance of engagement may be achieved. As Anthony Thomson and his co-authors identified in *Policing the Valley*, their 2003 book about rural and small-town policing in Nova Scotia's Annapolis Valley: "Where there is no political accountability to the community, it is possible to construct an advisory group (by hand-picking the membership), supposedly representative of community 'sectors,' which is distinct from formal political control, so that the force remains accountable to the community in only the most perfunctory way."[32]

In a roundtable on contemporary community policing, we heard from Dr. Sulaimon Giwa, a professor of social work at Memorial University in St. John's and chair of the Department of Criminology and Criminal Justice at St. Thomas University in Fredericton. Dr. Giwa provided a more substantive understanding of community-engaged policing:

> [C]ommunity policing is a nexus or a meeting point where police professionals and community partners engage in the deliberate and intentional work of identifying aspects of community life where things have not worked or are not working, and leverage each other's expertise and knowledge to arrive at solutions that can restore the community's sense of safety and well-being, and also enhance the legitimacy of the police in the process.[33]

Cal Corley, chief executive officer of the Community Safety Knowledge Alliance, former assistant commissioner of the RCMP, and an expert report writer for the Commission, gave this evaluation of police agencies' adoption of community-engaged policing in the same roundtable:

> [It] has never really taken root in most police organizations. I think most will say, absolutely, we – you know, that's our central organizing philosophy, but it hasn't engrained in the culture. Police culture in Canada largely, and certainly the RCMP, is one that places much greater value on the functions of criminal investigations, criminal intelligence and enforcement than on those other aspects.[34]

Dr. Giwa emphasized that, to succeed in the kind of community policing that his work envisages, police agencies must be prepared to relinquish some of their power. He explained on the basis of his research into the impediments of building more trusting relationships between police and 2SLGBTQI+ communities, police and racialized communities, and also the intersections of these communities:

> [W]hen we think about those two communities that … I've been alluding to, these concepts or these ideas are also put into disrepute because of the fact that, you know, the idea of power-sharing requires on some level a commitment and a willingness on the part of police to be able to take stock of their own privileges and their own power and how that actually cascades and manifests itself within the community around. And it also means for police to be able to take stock of what kind of power are they prepared to give up to the community to be true actors and players in the game of community safety and well-being.[35]

Dr. Hugh Russell, a social psychologist who co-authored with Dr. Giwa the second edition of *Transforming Community Policing* (2023), said in the same roundtable that evaluations of police legitimacy have focused on public trust in the police. He added this important caveat:

> [I]t has to include the other element as well, the perspective … that the police have [about] the people whom they are serving, to whom they are responding. And we have to have police respond in a fashion that indicates they fundamentally respect and approve of the people they're serving and they're anxious to engage with those people in ways that will be constructive for that relationship.[36]

Dr. Giwa's approach resonates with Dr. Loader's principles of policing, and we agree with Dr. Russell and Dr. Giwa that it lies at the heart of the work that police must do to regain their legitimacy as a democratic institution. It is this approach that must be worked into the everyday policing practices of Canadian police. Dr. Giwa emphasized, however, that this approach cannot be achieved using familiar strategies of consultation and efforts at incremental reform: "[T]his goal, however, is undermined by the sense of consultation fatigue that affected communities experience as a result of repeatedly participating in communication exercises or exchanges with police, in which solutions are offered to the police, but frequently do not manifest in reality."[37]

Dr. Amy Siciliano, the public safety advisor at the Halifax Regional Municipality, also emphasized at the roundtable the harmful dynamic in which community initiatives rely on grant funding, which ends, while policing relies on relatively stable continuing funding: "[C]ommunity shouldn't be expected to know which funding comes from what stream or what level of government, but they – I believe they should – you know, if they're coming to the table and working with us that they should know that we're committed for the long haul in this work."[38]

Police representatives emphasized the value of the work that community safety providers such as women's shelters contribute. Hubert (Hue) Martin, for example, who at the time of our roundtable on the structure of policing in Nova Scotia was transitioning from working for the RCMP as a plainclothes member in Yarmouth to serving as the director for the National Police Federation for Nova Scotia and Newfoundland, explained:

> I work hand in hand with the shelter, the Tri-County Women's Centre, and rely heavily on them.
>
> So, again, as a police officer, fully, fully support constant and ever-evolving funding for non-profits because it makes our job so much easier to work with these partners.[39]

However, when invited to offer examples of how police might re-envision their relationship with communities, police representatives tended to fall back on advisory committees and training programs. As C/Supt. Darren Campbell put it in his testimony:

> In terms of accomplishing that connectivity and that trust, there's a number of things that are very important for us to do. We talk a lot about consultative groups … When I arrived actually in Nova Scotia, there's a course called the ACE course, the African Canadian Experience. That was developed well before my arrival in Nova Scotia, and it's – it was actually developed in consultation with the African Nova Scotia Committee as well as a number of our officers who are actually from that community that are actually posted here to Nova Scotia. A number of initiatives through that. In fact, that course was delivered to many of our officers in Nova Scotia. We offered that to the Department of Justice in Nova Scotia, other police agencies. We shared our course training material and standards to other agencies.[40]

Robert Wright, an African Nova Scotian community leader and the executive director of the People's Counselling Clinic in Nova Scotia, offered a more substantive example of community-engaged policing in an interview with the Commission. He described an instance in which he was called by the Serious Incident Response Team to help members understand the evidence in a case in which two Black youths were charged with creating a disturbance, resisting arrest, and assaulting a police officer after an incident in a fast-food store which involved dozens of young people, most of whom were white. He characterized this example as "a story about policing young Black people and how [the] culture of policing and [the] culture of young people … and racialized young people intersects to end up in a snafu."[41] He described the charges laid against the young people as follows:

> Creating a disturbance, resisting arrest, assaulting a police officer. I call it the three-legged stool of police incompetence because in the absence of a fourth and originating charge, right, what is the disturbance that was created? Was the kid creating a disturbance? No. The disturbance occurred when the police began to escalate their interaction with him.
>
> And then, of course, he resisted an arrest because he wasn't being arrested for anything. And of course, you can't resist arrest without assaulting a police officer. Because in the amount of resistance you offer to a police officer who is seeking to touch your body is in effect an assault.[42]

Describing the experience of watching a video of the encounter, Mr. Wright explained:

> [Y]ou can see that there's a young man leaning on the counter in the counter-opening where the staff would pass. The kid is standing there, not creating a disturbance, he's macking on [flirting with] this girl … you can see a police officer approach the young man to speak to him. Now, the youth was not directed by staff to change where he was sitting or standing. But the police officer says he was standing in this brief and asked him to move. And the kid completely ignored the cop and kept talking with her … you could see the cop escalating, getting closer, talking to the youth. The youth was ignoring the cop, and then the cop did something that I would call the parental scoop. He simply took his arm

> and redirected the young person and moved him, moved his hips maybe twelve inches from here to here.
>
> Well, the kid turned around and [screamed] … and now we're in snafu, right? So, once you're in a police officer's face, the police kind of took him down, started to cuff him. There are probably 80 kids in [all], there are three Black kids among them. When the police started to engage with that Black young man, you could see 77 kids take two steps back and two kids take two steps forward. Guess who the kids were who took two steps forward? The Black kids.[43]

We note in passing that some aspects of this incident are reminiscent of the dynamic in *R v RDS*, [1997] 3 SCR 484, in which an African Nova Scotian youth came to the aid of his cousin, who was being arrested by police.[44] The cultural pattern of this dynamic is integral to Mr. Wright's point. He explained to us, as he had to the Serious Incident Response Team:

> [T]hat Black kid has been socialized to, if you're not doing anything wrong, you don't need to talk to a police officer ever, right? That kid is a Black kid who's been socialized that if the police are trying to violate your right, get in their face because you have the right to not be disturbed by police. The police have been socialized that you have the authority to interact with people and certainly Black people should be deferential to police authority …
>
> And with police, and racialized people, the deference is always in that direction, to police. And because that boy did not conform whereas 80 or 77 other young people did conform immediately, he was targeted for police as a snafu … Why? Because of police overzealous attempts to calm a situation that didn't need calming.[45]

Our purpose in relating this account in some detail is to demonstrate the significance of the cultural lens that Mr. Wright brings to the incident. Understanding that African Nova Scotian children are socialized in particular ways with respect to police, one can appreciate why the African Nova Scotian youths in this incident responded differently from their non-Black peers. Behaviours that the police interpret as defiance or disrespect are, to the young people involved, an appropriate response to the contravention of personal and legal boundaries.

Mr. Wright was brought into this case to serve as a cultural interpreter, a role he also plays at times within the court system. His knowledge and his capacity to operate as a cultural intermediary allowed the Serious Incident Response Team to understand this incident and approach its work on the basis of this understanding. We see his involvement as a substantive example of community-engaged policing of the kind Dr. Giwa envisions: a recognition of the expertise that can be found in the community, coupled with the humility to acknowledge that police may not always understand what they see or encounter. Mr. Wright was brought into the operational work of the Serious Incident Response Team to assist investigators to do their work more effectively.

Another example was supplied by Dr. Chambers in our roundtable on police and institutional responses to family and intimate partner violence, based on her work in Ontario with women who experience coercive control:

> [W]hat we've been doing in Thunder Bay is I have worked with our local shelter and designed a coercive control assessment that they use at the shelter when someone comes in that is a much more detailed document. It really takes quite – a couple of hours for them to work through. And it's also accompanied by a whole bunch of training materials talking about why each of the topics needs to be covered and talking about ways that you could explain it to someone who's a victim who might not recognize that the behaviours to which they've been subjected are actually abusive.
>
> And so I think that the wider assessment needs to be done outside of police and then police need to accept the assessments that are made by agencies that are better informed about what abusive relationships look like.[46]

Incorporating transformative community-engaged policing into everyday policing practices can follow this kind of pattern: police officers are able to recognize that their training and expertise does not equip them to understand an incident or a dynamic as well as a community-based expert can, and they have the humility to reach out to other agencies or community leaders for their help.

LESSONS LEARNED

Police decision-making is better when police recognize and draw on the expertise of community leaders and other community safety providers to help them understand their work.

In order to rebuild police legitimacy, police must interact with every community member in a way that indicates they fundamentally respect the people they are serving and behave in ways that will be constructive for relationships between police and community members.

Recommendation P.73

COMMUNITY-ENGAGED POLICING

The Commission recommends that

(a) Police agencies should adopt policies and practices that encourage front-line police to consult with community subject matter experts on questions that will help them better understand and serve their communities. These policies and practices should permit consultation on operational matters.

(b) Community subject matter experts should be paid fairly for their work, and police agencies should establish a budget for this purpose.

CHAPTER 14

Everyday Policing, Equality, and Safety

CHAPTER 14 Everyday Policing, Equality, and Safety

Throughout this Report, we have documented the evidence we heard and made findings and recommendations that point the way toward a paradigm shift in our community-wide approaches to policing, gender-based, intimate partner, and family violence. Preventive services and community agencies must receive stable funding so they can do their important work without fearing that effective programs will falter and carefully fostered community relationships will be lost with precarious grant-funding. We must shift our ecosystem of community safety to decentre police and punitive responses in favour of supporting violence prevention, early intervention, and the social determinants of community safety. Vast expertise exists outside policing: in women's shelters, within agencies that serve criminalized and marginalized populations, and among mental health workers, community leaders, and those who have lived experience of violence and marginalization. That expertise must be recognized, valued, and made central to our efforts to address violence.

At a systemic level, Dr. Jude McCulloch and Dr. JaneMaree Maher, professors at Monash University in Australia who also prepared an expert report for the Commission, suggest that police need to be equipped to recognize patterns of gender-based, intimate partner, and family violence. They caution, however, that the research suggests the issue is rarely lack of funding for police – or even poor police policies. The issue tends to be prioritizing "public" violence over gender-based or "private" violence. This prioritization suggests that "private" violence is something that involves police less than "public" violence. Dr. McCulloch and Dr. Maher suggest that there is a need for a cost-benefit analysis of giving more funding to the police when investment in preventive, non-police programs and services is needed to keep women safe. They state that "we need to invest in long-term primary prevention, which is gender equality. So we really see the issue being around consistent police response, the reprioritization, and police accountability, too; a duty of care to victim survivors."[1]

Within an ecosystem of community safety, police have a limited but crucial role to play. Improving police awareness of the dynamics and prevalence of gender-based violence, including coercive control, sexual assault, and intimate partner violence, will assist them in helping to improve the safety of women and girls and, therefore, that of the wider community. More fundamentally, shifting the police understanding of their day-to-day role is an ambitious but necessary step in the work to end gender-based violence. If police understand themselves as part of a community safety ecosystem, and approach their work accordingly, the questions they ask when they attend a call can expand from "Do I see a criminal offence here?" or "Do I have enough evidence to obtain a warrant?" to incorporate the question, "What needs to happen to ensure that this person is safe?" This last question is by far the most important. When one attends to the safety of a person who has experienced violence or is expressing fear, asking them how they can be safe and knowing what resources can assist in securing their safety, opens up the possibility of a quite different and far more collaborative approach to policing.

The examples reviewed in this Part of the volume suggest that some – perhaps many – front-line police are not sufficiently familiar with the existing criminal law and with patterns of gender-based violence to recognize when a complaint of gender-based violence provides a basis for further investigation or when a complainant's safety is at risk. Indeed, experts who work directly with women who experience gender-based violence spoke with one voice when they told us that "often women say what the risk is … and they're not believed."[2] The Susan (Susie) Butlin and Nicole Doucet examples, discussed in Chapter 12, reflect this pattern.

We stated in Volume 3, Violence, that mandatory arrest and charging policies have often failed to keep women safe and have resulted in unintended harms that in some cases endanger women. We recommended that mandatory arrest and charging policies should be replaced by frameworks for structured decision-making by police, with a focus on violence prevention. This reform will help to shift the role of responding police officers away from focusing on the question "What charge can be laid here?" and toward identifying what is happening to a woman survivor and what supports are needed to ensure her pathway to safety.

We note, however, that most existing risk assessment tools used by police and police training focus on determining whether there is a chargeable offence that can be prosecuted. The Barbra Schlifer Commemorative Clinic in Toronto has identified that these risk assessment tools tend not to be trauma informed or survivor-centric, and they do not consider intersecting identity factors. The Barbra Schlifer

Commemorative Clinic has been conducting research-based work to generate risk assessment tools and standardized frameworks for women who experience violence,

> understanding that women from specific cultural identities need services which are rooted in their cultural reality. Black women, racialized women, Indigenous women need services and supports which are rooted in their distinct and unique experiences. And that language plays a big role in the way women describe their violence.[3]

In a roundtable, Dr. Pamela Palmater, who is a head of the Centre for Indigenous Governance at Toronto Metropolitan University and a member of Eel River Bar First Nation, also explained that the Butlin example is an instance of police misunderstanding their responsibilities to begin and end with a decision about whether a charge should be laid:

> [T]his is a really good example of a disproportionate focus on a charge. So the issue isn't how do we prevent violence? How do we keep this woman safe? What can we do with all of the tools available to us? It's my sole job to see if there is a charge, that's what my focus is. If there isn't, that's it. But their legal obligation, under international human rights, is to prevent the violence, investigate fully the violence, and prosecution comes later. Like that's a secondary step. The first one is how do you keep the woman safe, which you have a legal obligation to do? It's a state obligation. Police are a state institution, whether it's federal or provincial.
>
> ... [The police] job isn't just to prevent convictable violence, it's all violence. And I think that's what's really missed in this. It was no concern for her, just whether or not they would get the charge.[4]

Similarly, in Volume 3, we identified the pattern of violence in the perpetrator's life and explained that, while concerns about the perpetrator were on occasion reported to the police, these concerns did not elicit effective police attention to the perpetrator. His violent behaviour and the widely shared community concerns about his violence were not recognized by police agencies in Nova Scotia. This disconnect arose owing to a failure to recognize the need to investigate the perpetrator even when police received information that should have raised red flags; poor record keeping; a lack of follow-up by police officers; and a lack of coordination

among police agencies. In turn, the perpetrator's privilege as a relatively wealthy white professional contributed to the police failure to see him as high risk, even when serious allegations were made about his behaviour and intentions.

As discussed above, the focus of the whole community safety ecosystem should instead be: How do we prevent further violence? This focus requires police to think of their duty as working with others to *prevent* further violence rather than simply responding to violence. This approach in turn requires seeing support services in the community as full partners in community safety. Such a change will enable each partner in community safety to focus on the part of that public safety web which best suits their knowledge and expertise. In any case, though, the primary obligation is to prevent violence and then to fully investigate it – and only then to consider charges and prosecution.

As we noted in Volume 3, research on the use of risk assessment tools shows that "victim fear" is not usually viewed as a principal category leading to an assessment of high risk, but more consideration should be given to a woman's own perception of harm and level of fear, given the evidence we heard that women in the situation are the best judges of the risk.[5] Improving police awareness of the dynamics and prevalence of gender-based violence, including coercive control, sexual assault, and intimate partner violence, will assist police in helping to improve the safety of women and girls, which in turn will keep us all safer.

Achieving this shift in approach will flow from implementation of our recommendations in Volume 3, Violence:

> **V.10** The Commission recommends that
>
> ...
>
> (b) The federal government initiate and support a collaborative process that brings together the gender-based violence advocacy and support sector, policy-makers, the legal community, community safety and law enforcement agencies, and other interested parties to develop a national framework for a women-centred approach to responding to intimate partner violence, including structured decision-making by police that focuses on violence prevention.
>
> (c) Provincial and territorial governments, working with gender-based violence advocacy and support sectors, develop policies and protocols for implementing this national framework to address jurisdiction-specific needs.

As we explained in detail in Volume 3, many Indigenous and racialized women do not report intimate partner violence, sexual violence, and other forms of gender-based violence to police because they expect they will not be believed or fear the consequences of attracting police attention. Systemic racism plays a role in producing a lack of trust in police, as does the fear of being criminalized when reporting abuse. These and other patterns further entrench the police failure to effectively counter gender-based violence.

Supporting the evidence supplied by Dr. McCulloch and Dr. Maher that intervening effectively with gender-based violence can help to prevent mass violence, Dr. Alison Marganski, associate professor and director of criminology in the Department of Anthropology, Criminology, and Sociology at Le Moyne College in Syracuse, New York, explained in a roundtable:

> [G]ender-based violence must be given a priority in policing, but we also need to recognize the interrelatedness of violence overall and see violence on a continuum from discrimination to forms of coercive control to physical and sexual violence to these large mass attacks that we see, these extremist or terrorist attacks.[6]

Educating police in these interrelationships and connections is an important step in changing police approaches to intimate partner violence, gender-based violence, and family violence.

It remains to be said that misogyny plays a role in the failings that we have documented in this Report. In his 2021 report, *Broken Lives, Broken Dreams: The Devastating Effects of Sexual Harassment on Women in the RCMP*, the Honourable Michel Bastarache identifies "entrenched issues of misogyny, racism and homophobia" within the RCMP.[7] A 2022 report published by the Feminist Alliance for International Action Canada provides a detailed analysis of "misogyny and racism in the culture of the RCMP," including a summary of other reviews and reports that have documented this culture. This report concludes:

> It is evident that the culture of misogyny, racism, and homophobia in the RCMP, identified by Justice Bastarache, affects not only the treatment of women who are employed by the RCMP, but also the treatment of the women whom the RCMP is intended to serve. The same "hard questions" that are raised by the RCMP's treatment of the women it employs are also raised by the RCMP's treatment of the women it polices.[8]

The 2022 report links the RCMP's failures to investigate and prevent violence against women to this institutional culture. Participants reminded us that these problems are not limited to the RCMP; they are also present in other Canadian police services. Indeed, as Dr. Maher observed, these problems are not limited to police:

> [W]e see the ways in which our institutions express or embody, even though they might say unwittingly, decisions about – decisions or attitudes that are misogynistic …
>
> I think there we can see immediately a sense of justification, a suspicion, a sense that women don't deserve safety or may have done something to provoke the violence against them and the kind of ready flippage into that sort of justification, I think, is not only a part of policing but it's part of everyday quotidian experiences that, in a sense, we all have a responsibility to think to and to respond to if police forces and institutions come from our society. They're a reflection of who we are, a reflection of how we hold ourselves accountable in a sense for this as well for these types of violence, for their dreadful outcomes, for their everyday banal evil in a sense.[9]

In Volume 3, Violence, and Volume 4, Community, we discuss strategies to counter the broader operation of misogyny within community and institutional attitudes toward gender-based violence.

While misogyny is not by any means limited to policing, the operation of misogyny within policing is particularly harmful to women's equality and can undermine achievements in law reform and efforts to modernize policy. Dr. Maher suggested that misogyny helps to explain why police fail to act on laws and implement procedures that have been designed to better protect women from violence:

> So I think the continuum around those ideas, those misogynistic ideas, is one that's really important to bear in mind. I think a very startling thing is the frequency, certainly in the Australian context, recently where police officers after two decades of discussion about appropriate family violence policing still talk as if women provoked it or pick up the phone and say, "Oh, here she is again. I'm not going to listen to her now." All of those things run directly against what their training suggests is important, what the evidence suggests is important, what we know about women's

> capacity to identify their own risk and the escalation of their own risk, and yet there's a readiness on every part of the spectrum to – for – to accept some mode or dismissal or misogyny.[10]

The same can be said of other attitudes that are inconsistent with equality and universal dignity, such as racism and homophobia. For example, in *Missing and Missed: Report of the Independent Civilian Review into Missing Person Investigations*, the Honourable Gloria J. Epstein documents the harmful effects of systemic heteronormative biases on police relations with community members who are 2SLGBTQI+, and on the protection that these communities thereby receive from police. She also explains how these problems compound when a community member is 2SLGBTQI+ and racialized.

In this Part, we have explained that these failures to investigate and prevent violence happen to a very large extent through the low-visibility, unreviewed decision-making of front-line police. Police bring to their work a set of largely unexamined assumptions about their role as police, about what real violence and real victims look like, and about what kinds of problems they can help to solve with their existing toolbox. We have set out five strategies for improving everyday policing practices and identified an overarching goal of shifting the police mindset from one of law enforcement based on an imperfect understanding of Canadian law to one of proactively working with other agencies to secure the safety of those who have experienced violence or fear of violence.

LESSON LEARNED

Naming and countering the operation of misogyny, racism, homophobia, and other inegalitarian attitudes within policing must be placed at the heart of strategies to improve everyday policing. If police continue to disbelieve women, operate in ignorance about how violence and trauma present, and work in a silo rather than as part of a coordinated community safety system, the problems we have documented in this Report will persist.

Recommendation P.74

COUNTERING SYSTEMIC BIAS

The Commission recommends that

Government, police agencies, and police education programs make the goal of identifying and countering the operation of misogyny, racism, homophobia, and other inegalitarian attitudes central to every strategy for improving the quality of everyday policing in Canada.

LESSONS LEARNED

Not every complaint received by police can or should result in charges being laid or a warrant being obtained. However, in every case in which a community member reports violence or a non-frivolous fear of violence to police, the police should consider it their primary responsibility to work with other agencies to prevent escalation of violent behaviours, to investigate, and to protect the safety of those who are at risk.

Recruiting and educating police with an eye to building a culture of respect for equality rights and commitment to countering gender-based violence is an essential part of community-engaged policing.

Documenting patterns of violence through good note taking and supervision, information sharing, and interoperability is critical to assist police and other gender-based violence advocacy and support sector members to identify and act upon red flags in communities.

Recommendation P.75

PREVENTING VIOLENCE AND PROTECTING SAFETY

The Commission recommends that

Government, police agencies, and police education programs emphasize that working with other gender-based violence advocacy and support sector members to prevent an escalation of violence and protect the safety of those who experience violence is the primary purpose of every police response to a complaint of violence or the expressed fear of violence.

Beyond external accountability mechanisms that we will discuss in Volume 6, Implementation: A Shared Responsibility to Act, the shift that needs to occur in policing requires strong leadership from the top. **Intimate partner violence, family violence, and gender-based violence needs to be a priority not just at the police force level but also at the national table of police chiefs.**

In the same way that Commr. Brenda Lucki came to terms with the need to admit that the RCMP, like many other Canadian institutions, must contend with its own systemic racism, the weight of reports and recommendations catalogued in our environmental scan of relevant existing reports shows that the RCMP and other police forces in Canada must accept that they are systemically misogynist. Then, from the leaders of each institution on down, there must be a commitment to address the epidemic of gender-based violence in a conscious, concerted way. With recognition, acceptance, and determination by police chiefs, and implementation of the recommendations made in this Report, the tide will begin to turn.

Notes

INTRODUCTION TO VOLUME 5

1. Gjørv Report, Preliminary English Version of Selected Chapters (August 2012): COMM0063561 at p 10.

PART A: THE CRITICAL INCIDENCE RESPONSE

INTRODUCTION

1. Transcript of recorded 911 calls, April 19, 2020, 08:00:00–11:29:52: COMM0014806 at lines 8417–41.

CHAPTER 1
Five Principles of Effective Critical Incident Response

1. Commissioned Report prepared by Dr. R. Blake Brown, *The History of Gun Control in Canada* (April 2022): COMM0053823, in Annex B.
2. Commissioned Report prepared by Dr. David C. Hofmann, Dr. Lorne L. Dawson and Willa Greythorn, *Core Definitions of Canadian Mass Casualty Events and Research on the Background Characteristics and Behaviour of Lone-Actor Public Mass Murderers*, (June 2022): COMM0059219, in Annex B.
3. A/Commr. Alphonse MacNeil (ret'd.), *Independent Review – Moncton Shooting – June 4, 2014*: COMM0050842 at p 2.
4. Mass Casualty Commission, Interview of Lia Scanlan (September 14, 2021): COMM0015883 at pp 3–4.
5. "RCMP appoint new commanding officer for provincial force in N.S.," Canadian Press (5 February 2014), online: https://atlantic.ctvnews.ca/rcmp-appoint-new-commanding-officer-for-provincial-force-in-n-s-1.1671404. We are here adapting the concept of independence set out in *White Burgess Langille Inman v Abbott & Halliburton*, 2015 SCC 23 at paras 11 and 32. However, this is not a direct application of the principle of independence of expert witnesses, because the context here is slightly different from that of adversarial legal proceedings.
6. Commissioned Report prepared by Bjørn Ivar Kruke*, Police and First-Responder Decision-Making During Mass Casualty Events* (May 2022): COMM0058374 at p 13.
7. Commissioned Report prepared by Bjørn Ivar Kruke*, Police and First-Responder Decision-Making During Mass Casualty Events* (May 2022): COMM0058374 at pp 13–14.
8. Commissioned Report prepared by Bjørn Ivar Kruke, *Police and First-Responder Decision-Making During Mass Casualty Events* (May 2022): COMM0058374 at p 18.
9. Commissioned Report prepared by Bjørn Ivar Kruke, *Police and First-Responder Decision-Making During Mass Casualty Events* (May 2022): COMM0058374 at p 18.
10. Frank Straub, Jack Cambria, Jane Castor, Ben Gorban, Brett Meade, David Waltemeyer and Jennifer Zeunik, Rescue, Response and Resilience, A Critical Incident Review of the Orlando Public Safety Response to the Attack on the Pulse Nightclub (2017): COMM0062479 at p 21.
11. Commissioned Report prepared by Laurence Alison and Neil Shortland, *Critical Incident Decision Making: Challenges of Managing Unique and High-Consequence Events* (May 2022): COMM0057772 at p 12.
12. Commissioned Report prepared by Laurence Alison and Neil Shortland, *Critical Incident Decision Making: Challenges of Managing Unique and High-Consequence Events* (May 2022): COMM0057772 at p 17.
13. Commissioned Report prepared by Laurence Alison and Neil Shortland, *Critical Incident Decision Making: Challenges of Managing Unique and High-Consequence Events* (May 2022): COMM0057772 at pp 16–17.
14. Commissioned Report prepared by Laurence Alison and Neil Shortland, *Critical Incident Decision Making: Challenges of Managing Unique and High-Consequence Events* (May 2022): COMM0057772 at p 17.

15. Commissioned Report prepared by Bjørn Ivar Kruke, *Police and First-Responder Decision-Making During Mass Casualty Events* (May 2022): COMM0058374 at pp 15–16.
16. Commissioned Report prepared by Curt Taylor Griffiths, *Interagency Communication, Collaboration, and Interoperability within Police Services and between Police Services and Other Emergency Services* (May 2022): COMM0058936 at pp 2–3.
17. B.I. Kruke, "Planning for crisis response: The case of the population contribution" (2015) *Safety and Reliability of Complex Engineered Systems*: COMM0058420 at p 179.
18. Gjørv Report - Preliminary English Version of Selected Chapters (August 2012): COMM0063561 at p 19.
19. Dr. Kevin Pollock, "Review of Persistent Lessons Identified Relating to Interoperability from Emergencies and Major Incidents since 1986" (October 2013), Emergency Planning College: COMM0058399.
20. Dr. Kevin Pollock, "Review of Persistent Lessons Identified Relating to Interoperability from Emergencies and Major Incidents since 1986" (October 2013), Emergency Planning College: COMM0058399 at p 6.
21. Dr. Kevin Pollock, "Review of Persistent Lessons Identified Relating to Interoperability from Emergencies and Major Incidents since 1986" (October 2013), Emergency Planning College: COMM0058399 at p 7.
22. Dr. Kevin Pollock, "Review of Persistent Lessons Identified Relating to Interoperability from Emergencies and Major Incidents since 1986" (October 2013), Emergency Planning College: COMM0058399 at p 7.
23. Kevin Pollock and Eve Coles, "Interoperability: Theory & Practice in UK Emergency Management'" Serco, EPC Occasional Paper Number 13 (1 April 2015), https://www.alnap.org/help-library/interoperability-theory-practice-in-uk-emergency-management, as quoted in Commissioned Report prepared by Curt Taylor Griffiths, *Interagency Communication, Collaboration, and Interoperability within Police Services and between Police Services and Other Emergency Services* (May 2022): COMM0058936 at p 7.
24. Commissioned Report prepared by Curt Taylor Griffiths, *Interagency Communication, Collaboration, and Interoperability within Police Services and between Police Services and Other Emergency Services* (May 2022): COMM0058936, in Annex B.
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CHAPTER 3
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CHAPTER 4
Public Safety During Critical Incidents

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PART B: THE CONTINUING CRISIS

CHAPTER 5
Post-Event Learning

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20. E-mail from RCMP Member to Costa Dimopoulos (RCMP) dated June 12, 2020: COMM0062679.
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22. RCMP, *Tactical Operations Manual* (TOM) – ch, 2.3. Operation Requirements, 26 August 2016, clause 2.1.3, online: Royal Canadian Mounted Police [COMM0040031].
23. RCMP, *Tactical Operations Manual* (TOM) – ch, 2.3. Operation Requirements, 26 August 2016, clause 3.1, online: Royal Canadian Mounted Police [COMM0040031].
24. RCMP, H Division ERT – After Action Report: COMM0054285 at pp 6–7.
25. RCMP Emergency Medical Response Team – After Action Report: COMM0054284 at pp 10–11.
26. Mass Casualty Commission, Final Written Submissions on Behalf of the Attorney General of Canada, [October 7, 2022] at para 90, online: https://masscasualtycommission.ca/files/documents/Final-Written_AG-Canada.pdf.
27. Mass Casualty Commission, Transcript of Proceedings, August 24, 2022: COMM0063224 at p 22.
28. Mass Casualty Commission, Transcript of Proceedings, May 16, 2022: COMM0058512 at p 141.
29. Mass Casualty Commission, Final Written Submissions on Behalf of the Attorney General of Canada, [October 7, 2022] at para 90, online: https://masscasualtycommission.ca/files/documents/Final-Written_AG-Canada.pdf.
30. Mass Casualty Commission, Transcript of Recorded Interview, August 24, 2022: COMM0063691 at p 27.
31. Mass Casualty Commission, Transcript of Recorded Interview, August 24, 2022: COMM0063691 at p 29.
32. Mass Casualty Commission, Transcript of Recorded Interview, August 24, 2022: COMM0063691 at p 29.
33. Mass Casualty Commission, Transcript of Recorded Interview, August 24, 2022: COMM0063691 at p 33.
34. Mass Casualty Commission, Transcript of Recorded Interview, September 15, 2022 at p 5: COMM0065065
35. RCMP National Operations Centre Organizational Chart (27 June 2021): COMM0055929 at p 5.
36. Mass Casualty Commission, Transcript of Proceedings, 23 August 2022: COMM0063059 at p 55 lines 20–22.
37. Mass Casualty Commission, Transcript of Proceedings, 23 August 2022: COMM0063059 at p 56 lines 12–13.
38. Mass Casualty Commission, Transcript of Proceedings, 23 August 2022: COMM0063059 at p 32 lines 4–5.
39. Mass Casualty Commission, Transcript of Proceedings, 23 August 2022: COMM0063059 at p 32 lines 15–17.

40. Mass Casualty Commission, Transcript of Proceedings, 23 August 2022: COMM0063059 at p 33 lines 19–20.
41. Mass Casualty Commission, Transcript of Proceedings, 23 August 2022: COMM0063059 at pp 32–33.
42. Mass Casualty Commission interview of Brian Brennan: COMM0063046 at pp 16–17.
43. Mass Casualty Commission, Transcript of Proceedings, 9 September 2022: COMM0064848 at p 55 lines 9–13.
44. Mass Casualty Commission interview of Chris Leather: COMM0059832 at p 19.
45. Mass Casualty Commission interview of Dennis Daley: COMM0065065 at 37.
46. Mass Casualty Commission interview of Dennis Daley: COMM0065065 at 22.
47. Handwritten notes of Dennis Dalley: COMM0064623 at p 5.
48. C/Supt. Leather, Supt. Dimopoulos, Supt. Campbell, Scott McCrossin (legal counsel), Cristine Kilfoil, A/Commr. Stubbs, C/Supt. Rupa, and A/Commr. Daley attended this meeting.
49. Supt. Santosuosso's notes of this meeting on May 27, 2020, state that the purpose of the meeting was to discuss "IOR," which is short for Independent Officer Review (Handwritten notes of Derek Santosuosso: COMM0058648 at p 23).
50. Handwritten notes of Derek Santosuosso: COMM0064525 at p 23. Litigation privilege is discussed in Volume 7.
51. Mass Casualty Commission interview of Dennis Daley: COMM0065065 at p 28. A/Commr. Daley initially placed this in May 2020 but subsequent discussion during his interview, as well as documentary evidence, indicates he stopped taking steps in early June 2020 rather than May 2020.
52. Mass Casualty Commission interview of Dennis Daley: COMM0065065 at p 41.
53. Email from Jamie Solesme to Dennis Daley, "Request for Assistance – H Division CIP Independent Assessment/Review" (15 December 2020): COMM0063670.
54. Email from Dennis Daley to Jamie Solesme, " RE: Request for Assistance – H Division CIP Independent Assessment/Review" (16 December 2020): COMM0063670.
55. Mass Casualty Commission interview of Dennis Daley: COMM0065065 at p 53.
56. Email from A/Commr Dennis Daley to C/Supt John Robin et al, "FW: 2021-0484 – H-Strong CIRR" (12 April 20201): COMM0065465 at 1–2.
57. "Critical Incident Response Review Rationale (questions 1 through 7)" (21 April 2021): COMM0065467.
58. Email from A/Commr. Dennis Daley to C/Supt. John Robin and C/Supt. Jamie Solesme, "H Strong – CIC review" (3 May 2021): COMM0063680.
59. Email from C/Supt. John Robin to A/Commr. Dennis Daley, "RE: H Strong – CIC review" (3 May 2021): COMM0063680.
60. Email from C&IP tasking to Osana Radidpour (26 May 2021): COMM0065402.
61. Email from C&IP tasking to Osana Radidpour, (26 May 2021): COMM0065402.
62. Mass Casualty Commission interview of Dennis Daley: COMM0065065 at p 66.

63. Mass Casualty Commission interview of Dennis Daley: COMM0065065 at pp 70–71.
64. Handwritten notes of C/Supt. MJ O'Malley (13 January 2022): COMM0065440.
65. "CIC Review & MCC Request Meeting Thursday, January 13th, 2022 @ 11:00am" (13 January 2022): COMM0065412 at p 3.
66. Mass Casualty Commission, Transcript of Proceedings, 27 July 2022: COMM0061294 at p 84 line 27.
67. Mass Casualty Commission, Transcript of Proceedings, 26 July 2022, at p 74 lines 1–5; Mass Casualty Commission, Transcript of Proceedings, 25 July 2022: COMM0061287 at p 72.
68. Mass Casualty Commission interview of Phil Lue: COMM0063691 at pp 40–41.
69. Mass Casualty Commission interview of Phil Lue: COMM0063691 at pp 46–4 .
70. Supt. Lue's spouse, who is also an RCMP member, was transferred to an international position in Thailand. Supt. Lue was accordingly required to move abroad with his family. Supt. Lue indicated that he was told by the RCMP that it would not be possible for him to do his position remotely once his spouse was transferred (Mass Casualty Commission interview of Phil Lue: COMM0063691 at p 3).
71. Mass Casualty Commission interview of Phil Lue: COMM0063691 at p 47.
72. Email from Supt. Phil Lue to C/Supt. Michael O'Malley & C/Supt. Jamie Solesme, "RE: CIC Review for Mass Shooting" (6 July 2022): COMM0063681 at p 1.
73. Mass Casualty Commission interview of Dennis Daley: COMM0065065 at pp 71–72.
74. Mass Casualty Commission interview of Dennis Daley: COMM0065065 at pp 60, 72.
75. Affidavit of Jamie Solesme (25 August 2022): COMM0063516 at p 6.
76. Mass Casualty Commission, Transcript of Proceedings, 23 August 2022: COMM0063059 at pp 55–56; Mass Casualty Commission, Transcript of Proceedings, 24 August 2022: COMM0063224 at pp 20–21, 23–24; Mass Casualty Commission interview of Brian Brennan: COMM0063046 at 66.
77. See, for example, Mass Casualty Commission interview of Brian Brennan: COMM0063046 at pp 58, 112–13.
78. Mass Casualty Commission interview of Dennis Daley: COMM0065065 at p 61; see also Mass Casualty Commission, Transcript of Proceedings, 9 September 2022: COMM0064848 at p 118.
79. Mass Casualty Commission, Transcript of Proceedings, 9 September 2022: COMM0064848 at p 114.
80. Mass Casualty Commission interview of Dennis Daley: COMM0065065 at pp 74–77.
81. Mass Casualty Commission, Transcript of Proceedings, 9 September 2022: COMM0064848 at p 116 lines 11–13.
82. Mass Casualty Commission interview of Costa Dimopoulos: COMM0063690 at p 58.
83. Doug LePard, Missing Women Investigation Review (Vancouver Police Department: August 2010), online: https://vpd.ca/wp-content/uploads/2021/06/missing-women-investigation-review.pdf at 18.

84. Wally T Oppal, *Forsaken: The Report of the Missing Women Commission of Inquiry, Executive Summary* (19 November 2012), online: https://www2.gov.bc.ca/assets/gov/law-crime-and-justice/about-bc-justice-system/inquiries/forsaken-es.pdf atpp 52–53, 77.
85. Mass Casualty Commission interview of Dennis Daley: COMM0065065 at pp 67, 75–76.

CHAPTER 6
RCMP Public Communications and Internal Relations After the Mass Casualty

1. Email from Duane Cooper on behalf of A/Commr. Bergerman, "SITREP Update to Comm – Multiple Homicides, "H" Division (Limited Distribution)" (19 April 2020): COMM0016263; RCMP, "Minutes for CrOps meeting" (19 April 2020): COMM0009049 at pp 4, 6; Email from Lia Scanlan to HQ Media Relations, Jolene Bradley, Daniel Brien, Liam Gerofsky, and Sharon Tessier, "For review: Fwd: Urgent Canadian Press request" (19 April 2020): COMM0016755.
2. Michael Tutton and Holly McKenzie-Sutter, "Relatives, legal experts say NS should begin work on inquiry into mass killing," Canadian Press (27 April 2020), online: CTV News, https://atlantic.ctvnews.ca/relatives-legal-experts-say-n-s-should-begin-work-on-inquiry-into-mass-killing-1.4913636.
3. RCMP *Operational Manual*, "Ch. 27.1: Media Relations" (24 April 2014) at s 4.2.: [Exhibit P-003937 / COMM0039871].
4. RCMP *Operational Manual*, "Ch. 27.1: Media Relations" (24 April 2014) at ss 1.3.: [Exhibit P-003937 / COMM0039871].
5. RCMP *Operational Manual*, "Ch. 27.2: Media Releases" (4 July 2018): [Exhibit P-002580 / COMM0039872].
6. RCMP *Operational Manual*, "Ch. 27.2: Media Releases" (4 July 2018) at s. 2: [Exhibit P-002580 / COMM0039872].
7. RCMP *Operational Manual*, "Ch. 41.3: Human Deaths" (14 June 2018) at s. 3.1.6: [Exhibit P-002294 / COMM0039885].
8. RCMP *Operational Manual*, "Ch. 25.3: Major Case Management" (28 December 2011) at s 2.2.2.1: [Exhibit P-002293 / COMM0039869].
9. RCMP *Operational Manual*, "Ch. 25.3: Major Case Management" (28 December 2011) at ss 5.1. and 5.2.: [Exhibit P-002293 / COMM0039869].
10. RCMP *Operational Manual*, "Ch. 25.3: Major Case Management" (28 December 2011) at s 5.3.: [Exhibit P-002293 / COMM0039869].
11. RCMP *Operational Manual*, "Ch. 25.3: Major Case Management" (28 December 2011) at s 9.3.: [Exhibit P-002293 / COMM0039869].
12. RCMP *Operational Manual*, "Ch. 27.3: Media Inquiries" (26 April 2006) at s 1.3 in RCMP, "National Policies Booklet" (2 June 2022) at 356: [Exhibit P-002460 / COMM0058879].
13. RCMP *Operational Manual*, "Ch. 27.3: Media Inquiries" (26 April 2006) at s 1.3 in RCMP "National Policies Booklet" (2 June 2022) at 356 s 1.3: [Exhibit P-002460 / COMM0058879].
14. RCMP *Operational Manual*, "Ch. 27.3: Media Inquiries" (26 April 2006) at s 3.1 in RCMP "National Policies Booklet" (2 June 2022) at 357:[Exhibit P-002460 / COMM0058879].
15. RCMP *Operational Manual*, "Ch. 27.4: News Releases and Conferences" (24 June 2016) at s 2.1 in RCMP "National Policies Booklet" (2 June 2022) at p 359 [Exhibit P-002460 / COMM00588
16. RCMP Operational Manual, "Ch. 27.4: News Releases and Conferences" (24 June 2016) at s 2.1 in RCMP "National Policies Booklet" (2 June 2022) at 359 [Exhibit P-002460 /

COMM0058879]; Mass Casualty Commission, Transcript of Proceedings, August 6 2022: COMM005894 at p 82 lines 8–12.

17. RCMP Operational Manual, "Ch. 27.4: News Releases and Conferences" (24 June 2016) at s 2.7 in RCMP "National Policies Booklet" (2 June 2022) at p 359 [Exhibit P-002460 / COMM0058879]. See also: Affidavit of Inspector Pharanae Croisetiere (August 11, 2022): COMM0062461 at para 138.
18. RCMP, "Administration Manual: ch XIII.1 National Communications – Communication Services" (19 November 2003): COMM0039705.
19. RCMP, "Administration Manual: ch XIII.1 National Communications – Communication Services" (19 November 2003) at s D.1.b: COMM0039705.
20. RCMP, "Administration Manual: ch XIII.1 National Communications – Communication Services" (19 November 2003) at s. D.1.d: COMM0039705.
21. RCMP, "Administration Manual: ch XIII.1 National Communications – Communication Services" (19 November 2003) at s D.1. j: COMM0039705.
22. RCMP, "Administration Manual: ch XIII.1 National Communications – Communication Services" (19 November 2003) at s D.1. k.: COMM0039705.
23. Canada, Task Force on Governance and Cultural Change in the RCMP, *Rebuilding the Trust* (December 2007) at 39, online: Public Safety Canada, https://www.publicsafety.gc.ca/cnt/cntrng-crm/tsk-frc-rcmp-grc/_fl/archive-tsk-frc-rpt-eng.pdf.
24. Canada, Task Force on Governance and Cultural Change in the RCMP, *Report: Rebuilding the Trust* (December 2007) at p 40 [Recommendation 39], online: Public Safety Canada, https://www.publicsafety.gc.ca/cnt/cntrng-crm/tsk-frc-rcmp-grc/_fl/archive-tsk-frc-rpt-eng.pdf.
25. Canada, RCMP Reform Implementation Council, *Final Report: From Reform to Continuous Improvement: The Future of the RCMP* (December 2010) at p 19.
26. Canada, RCMP Reform Implementation Council, *Final Report: From Reform to Continuous Improvement: The Future of the RCMP* (December 2010).
27. Commission for Public Complaints Against the RCMP, "Report Following a Chair-Initiated Complaint and Public Interest Investigation into the RCMP Member-Involved Shooting Death of John Simon," Civilian Review and Complaints Commission for the RCMP (December 2010) at p 36, online: https://www.crcc-ccetp.gc.ca/pdf/JohnIR-eng.pdf.
28. "Chairperson's Final Report After Commissioner's Response Regarding the RCMP's Response to the 2013 Flood in High River, Alberta," Civilian Review and Complaints Commission for the RCMP (April 2016) at Finding 43: [Exhibit P-004406 / COMM0061741].
29. "Chairperson's Final Report After Commissioner's Response Regarding the RCMP's Response to the 2013 Flood in High River, Alberta," Civilian Review and Complaints Commission for the RCMP (April 2016) at Findings 44 and 45: [Exhibit P-004406 / COMM0061741].
30. "Chairperson's Final Report After Commissioner's Response Regarding the RCMP's Response to the 2013 Flood in High River, Alberta," Civilian Review and Complaints Commission for the RCMP (April 2016) at Finding 46: [Exhibit P-004406 / COMM0061741].

31. "Chairperson's Final Report After Commissioner's Response Regarding the RCMP's Response to the 2013 Flood in High River, Alberta," Civilian Review and Complaints Commission for the RCMP (April 2016) at Finding 47: [Exhibit P-004406 / COMM0061741].
32. "Chairperson's Final Report After Commissioner's Response Regarding the RCMP's Response to the 2013 Flood in High River, Alberta," Civilian Review and Complaints Commission for the RCMP (April 2016) at Recommendation 2: [Exhibit P-004406 / COMM0061741].
33. "Chairperson's Final Report After Commissioner's Response Regarding the RCMP's Response to the 2013 Flood in High River, Alberta," Civilian Review and Complaints Commission for the RCMP (April 2016) at p 7: [Exhibit P-004406 / COMM0061741]. See also: Letter from Commissioner Bob Paulson to Ian McPhail, "RCMP Response to High River Report" (2 December 2016): COMM0061742.
34. RCMP, "Emergency Response Operations Guide" (rec'd 29 July 2021) at p 29: COMM0059514.
35. Mass Casualty Commission, Transcript of Proceedings, 8 June 2022: COMM0058948 [Lia Scanlan]; Mass Casualty Commission, Transcript of Proceedings, 23 August 2022, at p 96 lines 7–11: COMM0063059 [Brenda Lucki]; Mass Casualty Commission, Transcript of Proceedings, 27 July 2022, at p 32: COMM0061294 [Chris Leather].
36. Mass Casualty Commission, Foundational Document, "Public Communications from the RCMP and Governments about the Mass Casualty – Appendix of Press Briefing Transcripts" (May 2022): COMM0057762 at p 6.
37. Mass Casualty Commission, Foundational Document, "Public Communications from the RCMP and Governments about the Mass Casualty – Appendix of Press Briefing Transcripts" (May 2022): COMM0057762 at p 10.
38. Mass Casualty Commission, Foundational Document, "Public Communications from the RCMP and Governments about the Mass Casualty – Appendix of Press Briefing Transcripts" (May 2022): COMM0057762 at p 6.
39. Mass Casualty Commission, Transcript of Proceedings, 8 June 2022: COMM0058948 at pp 81 lines 22–28, 82 lines 8–12 [Lia Scanlan testimony]. See also: Mass Casualty Commission, "Transcript of Recorded Interview of Lia Scanlan" (2 February 2022): COMM0058826 at pp 65–67.
40. Mass Casualty Commission, Transcript of Proceedings, 27 July 2022: COMM0061294 at p 32 lines 9–10 [Chris Leather].
41. Email from Lia Scanlan to HQ Media Relations / DG Relations Medias (RCP/GRC) and others, "For review: Fwd: Urgent Canadian Press request" (19 April 2020): COMM0016756 at p 12 para 9.
42. Mass Casualty Commission, "Foundational Document – Public Communications from the RCMP and Governments about the Mass Casualty – Appendix of Press Briefing Transcripts" (May 2022): COMM0057762 at p 12 para 9.
43. Email from Steve Halliday to Laura Seeley and Angela McKay, "Fw: Criminal Operations Officer Update" (20 April 2020): COMM0016294.

44. Email from Laura Seeley to Steve Halliday and Angela McKay, "Re: Fw: Criminal Operations Officer Update" (20 April 2020): COMM0016294.
45. Mass Casualty Commission, Transcript of Proceedings, 28 July 2022: COMM0061295 at p 45 lines 20–25 [C/Supt. Chris Leather].
46. Mass Casualty Commission, "Foundational Document – Public Communications from the RCMP and Governments about the Mass Casualty – Appendix of Press Briefing Transcripts" (May 2022): COMM0057762 at p 5 para 4.
47. Mass Casualty Commission, "Foundational Document – Public Communications from the RCMP and Governments about the Mass Casualty – Appendix of Press Briefing Transcripts" (May 2022): COMM0057762 at p 27.
48. Mass Casualty Commission, Transcript of Proceedings, 27 July 2022: COMM0061294 at 39 lines 20–25 [C/Supt. Chris Leather].
49. Mass Casualty Commission, "Foundational Document – Public Communications from the RCMP and Governments about the Mass Casualty – Appendix of Press Briefing Transcripts" (May 2022): COMM0057762 at p 5 para 4.
50. Mass Casualty Commission, Transcript of Proceedings, 27 July 2022: COMM0061294 at p 41 line 13: [C/Supt. Chris Leather].
51. Mass Casualty Commission, "Foundational Document – Public Communications from the RCMP and Governments about the Mass Casualty – Appendix of Press Briefing Transcripts" (May 2022): COMM0057762 at p 27.
52. Mass Casualty Commission, Transcript of Proceedings, 27 July 2022: COMM0061294 at p 47 lines 21–22 [C/Supt. Chris Leather].
53. Mass Casualty Commission, Transcript of Proceedings, 26 July 2022: COMM0061291 at 24 lines 5–7 [Supt. Darren Campbell].
54. Lori Ward, Patricia MacPhee, and Heidi Collicutt, "Final Written Submissions on Behalf of the Attorney General of Canada" Attorney General of Canada (7 October 2022): COMM0065680 at paras 31–32.
55. Lori Ward, Patricia MacPhee and Heidi Collicutt, "Final Written Submissions on Behalf of the Attorney General of Canada," Attorney General of Canada (7 October 2022): COMM0065680 at para 32.
56. Minister Mark Furey, "Responses to MCC questions" (22 August 2022): COMM0063694 at p 9.
57. Minister Mark Furey, "Responses to MCC questions" (22 August 2022): COMM0063694 at p 8.
58. Mass Casualty Commission , "Transcript of Recorded Interview with Mark Furey" (6 September 2022): COMM0065058 at p 15.
59. Mass Casualty Commission, Transcript of Proceedings, 23 August 2022: COMM0063059 at p 99 lines 20–26 [Brenda Lucki].
60. Mass Casualty Commission, Transcript of Proceedings, 8 June 2022: COMM0058948 at p 110 lines 4–5, 23 [Lia Scanlan].
61. Mass Casualty Commission, Transcript of Proceedings, 8 June 2022: COMM0058948 at p 110 lines 23–26 [Lia Scanlan].

62. Email from Lia Scanlan to Cindy Bayers and others, "The go forward" (25 April 2020): COMM0034810.
63. Email from Lia Scanlan to Cindy Bayers and others, "The go forward" (25 April 2020): COMM0034810.
64. Email from Lia Scanlan to Cindy Bayers and others, "The go forward" (25 April 2020): COMM0034810.
65. Email from Lia Scanlan to Cindy Bayers and others, "The go forward" (25 April 2020): COMM0034810.
66. Email from Lia Scanlan to H Division Command A command, including A/Commr. Bergerman, C/Supt. Leather, and Supt. Campbell, "Fwd: The go forward" (April 25, 2020): COMM0034809.
67. Mass Casualty Commission, Transcript of Proceedings, 23 August 2022: COMM0063059 at pp 99 line 28, 100 lines 1–3, 5–12, 14–16 [Brenda Lucki].
68. Mass Casualty Commission, Transcript of Proceedings, 23 August 2022: COMM0063059 at p 100 lines 15–16 [Brenda Lucki].
69. Mass Casualty Commission, "Transcript of Recorded Interview of Deputy Commissioner Brian Brennan" (10 August 2022): COMM0063046 at p 31.
70. Mass Casualty Commission, Transcript of Proceedings, 23 August 2022: COMM0063059 at 96 lines 14–19 [Brenda Lucki].
71. Mass Casualty Commission, "Transcript of Recorded Interview of Deputy Commissioner Brian Brennan" (10 August 2022): COMM0063046 at pp 31–32.
72. Handwritten Notes OF Deputy Commissioner Brian Brennan (23 April 2020): COMM0059954 at p 7; See also: Mass Casualty Commission, "Transcript of Recorded Interview of Deputy Commissioner Brian Brennan" (10 August 2022): COMM0063046 at pp 36–37.
73. Handwritten Notes of Deputy Commissioner Brian Brennan (23 April 2020): COMM0059954 at p 7.
74. Handwritten Notes of Deputy Commissioner Brian Brennan,(23 April 2020): COMM0059954 at p 7.
75. Mass Casualty Commission, "Transcript of Recorded Interview of Rob O'Reilly" (18 August 2022) at p 53.
76. Mass Casualty Commission, "Transcript of Recorded Interview of Costa Dimopoulos" (30 August 2022): COMM0063690 at p 69.
77. Mass Casualty Commission, "Transcript of Recorded Interview of Rob O'Reilly" (18 August 2022) at p 53.
78. Mass Casualty Commission, "Transcript of Recorded Interview of Rob O'Reilly" (18 August 2022) at pp 53–54.
79. Mass Casualty Commission, Transcript of Proceedings, 23 August 2022: COMM0063059 at pp 166 lines 24–27, 167 lines 12–16 [Brenda Lucki].
80. Mass Casualty Commission, "Transcript of Recorded Interview of Rob O'Reilly" (18 August 2022) at p 54.

81. Mass Casualty Commission, Transcript of Proceedings, 23 August 2022: COMM0063059 at p 99 lines 2–5 [Brenda Lucki].
82. Mass Casualty Commission, "Public Communications from the RCMP and Governments: Appendix of Press Briefing Transcripts," May 10, 2022: COMM0057762 at p 52.
83. Mass Casualty Commission, "Public Communications from the RCMP and Governments: Appendix of Press Briefing Transcripts," May 10, 2022: COMM0057762 at p 55.
84. Mass Casualty Commission, "Public Communications from the RCMP and Governments: Appendix of Press Briefing Transcripts," May 10, 2022: COMM0057762 at p 60.
85. Mass Casualty Commission, "Public Communications from the RCMP and Governments: Appendix of Press Briefing Transcripts," May 10, 2022: COMM0057762 at p 62.
86. Mass Casualty Commission, "Transcript of Recorded Interview of Brenda Lucki," August 4, 2022: COMM0062475 at pp 12–13.
87. Mass Casualty Commission, Email from Brenda Lucki to Zita (PS/SP) Astravas, "RE: NWEST Examination," April 23, 2020: COMM0059637.
88. Mass Casualty Commission, "Transcript of Recorded Interview of Brenda Lucki," August 4, 2022: COMM0062475 at p 29.
89. Mass Casualty Commission, "Transcript of Recorded Interview of Brenda Lucki," August 4, 2022: COMM0062475 at p 30.
90. Mass Casualty Commission, "Transcript of Telephone Conference between H Division and the RCMP Commissioner, post the press conference, part 3 of 3," April 28, 2020: COMM0065722 at p 1.
91. Mass Casualty Commission, Email from Lia Scanlan to Brian Brennan, "RE: Per discussion," April 28, 2020: COMM0049334.
92. Mass Casualty Commission, "Transcript of Recorded Interview of Deputy Commissioner Brian Brennan," August 10, 2022: COMM0063046 at p 47. See also, Mass Casualty Commission, "Transcript of Recorded Interview of Brenda Lucki," August 4, 2022: COMM0062475 at pp 9–11.
93. Mass Casualty Commission, "Transcript of Recorded Interview of Deputy Commissioner Brian Brennan," August 10, 2022: COMM0063046 at p 47.
94. Mass Casualty Commission, "Transcript of Recorded Interview of Deputy Commissioner Brian Brennan," August 10, 2022: COMM0063046 at p 47.
95. Mass Casualty Commission, "Transcript of Recorded Interview of Brenda Lucki," August 4, 2022: COMM0062475 at p 34.
96. Mass Casualty Commission, "Transcript of Recorded Interview of Brenda Lucki," August 4, 2022: COMM0062475 at p 34.
97. Mass Casualty Commission, "Transcript of Telephone Conference between H Division and the RCMP Commissioner, post the press conference, part 1 of 3," April 28, 2020: COMM0065720 at p 1.
98. Mass Casualty Commission, "Transcript of Telephone Conference between H Division and the RCMP Commissioner, post the press conference, part 1 of 3," April 28, 2020: COMM0065720 at p 1.

99. Mass Casualty Commission, "Transcript of Telephone Conference between H Division and the RCMP Commissioner, post the press conference, part 1 of 3," April 28, 2020: COMM0065720 at p 1.
100. Mass Casualty Commission, "Transcript of Telephone Conference between H Division and the RCMP Commissioner, post the press conference, part 1 of 3," April 28, 2020: COMM0065720 at p 2.
101. Mass Casualty Commission, "Transcript of Telephone Conference between H Division and the RCMP Commissioner, post the press conference, part 1 of 3," April 28, 2020: COMM0065720 at p 1.
102. Mass Casualty Commission, "Transcript of Telephone Conference between H Division and the RCMP Commissioner, post the press conference, part 1 of 3," April 28, 2020: COMM0065720 at p 3.
103. Mass Casualty Commission, "Transcript of Telephone Conference between H Division and the RCMP Commissioner, post the press conference, part 2 of 3," April 28, 2020: COMM0065721 at pp 1–2.
104. Mass Casualty Commission, "Transcript of Telephone Conference between H Division and the RCMP Commissioner, post the press conference, part 2 of 3," April 28, 2020: COMM0065721 at p 2.
105. Mass Casualty Commission, "Transcript of Telephone Conference between H Division and the RCMP Commissioner, post the press conference, part 2 of 3," April 28, 2020: COMM0065721 at p 2.
106. Mass Casualty Commission, "Transcript of Telephone Conference between H Division and the RCMP Commissioner, post the press conference, part 2 of 3," April 28, 2020: COMM0065721 at pp 2–3.
107. Mass Casualty Commission, "Transcript of Telephone Conference between H Division and the RCMP Commissioner, post the press conference, part 3 of 3," April 28, 2020: COMM0065722 at p 1 .
108. Mass Casualty Commission, "Transcript of Telephone Conference between H Division and the RCMP Commissioner, post the press conference, part 3 of 3," April 28, 2020: COMM0065722 at p 1.
109. Mass Casualty Commission, "Transcript of Telephone Conference between H Division and the RCMP Commissioner, post the press conference, part 3 of 3," April 28, 2020: COMM0065722 at p 2.
110. Mass Casualty Commission, "Transcript of Telephone Conference between H Division and the RCMP Commissioner, post the press conference, part 3 of 3," April 28, 2020: COMM0065722 at pp 1–2.
111. Mass Casualty Commission, "Transcript of Telephone Conference between H Division and the RCMP Commissioner, post the press conference, part 3 of 3," April 28, 2020: COMM0065722 at p 3.
112. Mass Casualty Commission, "Transcript of Telephone Conference between H Division and the RCMP Commissioner, post the press conference, part 3 of 3," April 28, 2020: COMM0065722 at p 4.

113. Mass Casualty Commission, "Transcript of Proceedings of Commr. Brenda Lucki," August 23, 2022: COMM0063059 at pp163–164.
114. Commissioned report prepared by Joel Negin, Philip Alpers & Rebecca Peters, "Firearm Regulation in Australia: Insights from International Experience and Research," August 30, 2022: COMM0063634 at p 7.
115. Mass Casualty Commission, "Transcript of Recorded Interview of Lee Bergerman," August 2, 2022: COMM0062441 at p 50.
116. Mass Casualty Commission, "Transcript of Recorded Interview of Lee Bergerman," August 2, 2022: COMM0062441 at p 50.
117. Mass Casualty Commission, "Transcript of Recorded Interview of Supt. Darren Campbell," July 12, 2022: COMM0059935 at pp 14–15.
118. Mass Casualty Commission, "Transcript of Recorded Interview of Supt. Darren Campbell," July 12, 2022: COMM0059935 at pp 20–21.
119. Mass Casualty Commission, "Transcript of Recorded Interview of C/Supt. Chris Leather," July 6, 2022: COMM0059832 at p 136.
120. Mass Casualty Commission, "Transcript of Recorded Interview of Brenda Lucki," August 4, 2022: COMM0062475 at p 34.
121. Mass Casualty Commission, "Transcript of Proceedings of Commr. Brenda Lucki," August 23, 2022: COMM0063059 at pp 138–39.
122. Mass Casualty Commission, "Transcript of Recorded Interview of Lee Bergerman," August 2, 2022: COMM0062441 at p 50.
123. Mass Casualty Commission, "Transcript of Recorded Interview of Lee Bergerman," August 2, 2022: COMM0062441 at p 51.
124. Mass Casualty Commission, "Transcript of Recorded Interview of Deputy Commissioner Brian Brennan," August 10, 2022: COMM0063046 at p 50.
125. Mass Casualty Commission, "Transcript of Proceedings of D/Commr. Brian Brennan," September 9, 2022: COMM0064848 at pp 12–13.
126. Mass Casualty Commission, "Transcript of Recorded Interview of Brenda Lucki," August 4, 2022: COMM0062475 at pp 35–36.
127. Commissioned Summary Report prepared by Quintet Consulting Corporation, "Summary Report Wellness Assessment 'H' Division Royal Canadian Mounted Police," September 30, 2021: COMM0063605 at p 13.
128. Commissioned Summary Report prepared by Quintet Consulting Corporation, "Summary Report Wellness Assessment "H" Division Royal Canadian Mounted Police," September 30, 2021: COMM0063605 at p 13.
129. Commissioned Summary Report prepared by Quintet Consulting Corporation, "Summary Report Wellness Assessment 'H' Division Royal Canadian Mounted Police," September 30, 2021: COMM0063605 at p 10.
130. Commissioned Summary Report prepared by Quintet Consulting Corporation, "Summary Report Wellness Assessment 'H' Division Royal Canadian Mounted Police," September 30, 2021: COMM0063605 at p 14.

131. Email from Dennis Daley, "Re Media Reports," May 19, 2020: COMM0020386; See also, Mass Casualty Commission, "Transcript of Recorded Interview of Costa Dimopoulos," August 30, 2022: COMM0063690 at pp 53–54.
132. Mass Casualty Commission, "Transcript of Recorded Interview of Costa Dimopoulos," August 30, 2022: COMM0063690 at pp 53–54.
133. Mass Casualty Commission, "Transcript of Proceedings of A/Commr. Lee Bergerman," August 22, 2022: COMM0063188 at p 12.
134. Mass Casualty Commission, "Transcript of Proceedings of Commr. Brenda Lucki," August 23, 2022: COMM0063059 at pp 127–28.
135. Mass Casualty Commission, "Transcript of Proceedings of Commr. Brenda Lucki," August 24, 2022: COMM0063224 at pp 78–79.
136. Mass Casualty Commission, "Transcript of Recorded Interview of Lia Scanlan," February 2, 2022: COMM0058826 at p 79.
137. Email correspondence from Lia Scanlan to Chris Leather, Darren Campbell and Lee Bergerman, "Re: Reply and heads up: FW: Hello from CBC the fifth estate," October 1, 2020: COMM0054895 at pp 1–2.
138. Commissioned Summary Report prepared by Quintet Consulting Corporation, "Summary Report Wellness Assessment 'H' Division Royal Canadian Mounted Police," September 30, 2021: COMM0063605 at p 15.
139. Mass Casualty Commission, "Transcript of interview of Stuart Beselt," July 30, 2021: COMM0015529 at p 51.
140. Mass Casualty Commission, "Transcript of Recorded Interview of Costa Dimopoulos," August 30, 2022: COMM0063690 at p 97.
141. Mass Casualty Commission, "Transcript of Recorded Interview of C/Supt. Chris Leather," July 6, 2022: COMM0059832. See also, Mass Casualty Commission, "Transcript of Recorded Interview of Supt. Darren Campbell," July 12, 2022: COMM0059935.
142. Mass Casualty Commission, "Transcript of Telephone Conference between H Division and the RCMP Commissioner, post the press conference, part 3 of 3," April 28, 2020: COMM0065722 at p 1.
143. "RCMP Crisis Communications Reference Guide and Standard Operating Procedures," April 2022: COMM0059656.

CHAPTER 7
Issues Management and Interagency Conflict in the Post-Crisis Period

1. RCMP, "New Business Case Proposal for: Issues Management Team" (21 July 2020): COMM0064522 at p 8.
2. "RCMP Crisis Communications Reference Guide and Standard Operating Procedures," April 2022: COMM0059656 at p 6.
3. Mass Casualty Commission, "Transcript of Recorded Interview of Lee Bergerman" (2 August 2022): COMM0062441 at pp 61, 64.
4. Mass Casualty Commission, "Transcript of Recorded Interview of Lee Bergerman" (2 August 2022) at 62: COMM0062441, at p 62 [similar statement also at p 65].
5. Mass Casualty Commission, "Transcript of Recorded Interview of Lee Bergerman" (2 August 2022): COMM0062441 at p 65. An example of the latter is the RCMP's decision after the mass casualty to stop selling decommissioned police cars: "what the Issues Management Team … for example, decommissioning of police cars and how does a person get four police cars? Well, that needed to be fleshed out. How does that happen? How do we decommission police cars? And eventually, not too long after this incident, we stopped selling decommissioned police cars, and I … and I'm not even sure they've started selling them again."
6. RCMP, "New Business Case Proposal for: Issues Management Team" (21 July 2020): COMM0064522 at p 2.
7. RCMP, "New Business Case Proposal for: Issues Management Team" (21 July 2020): COMM0064522 at p 3.
8. Email from Derek Santosuosso to Amanda Doyle et al, "Issues Management Team Mandate" (4 May 2020): COMM0037383 at p 1.
9. RCMP, "New Business Case Proposal for: Issues Management Team" (21 July 2020): COMM0064522 at p 5.
10. Email from Dennis Daley to Chris Leather "Re: C+IP Support and Input- H-Strong" (29 April 2020): COMM0035705.
11. Response, "RCMP Subpoena for Written Evidence dated March 7, 2022": COMM0062335 at p 17. See also: "Consolidated Response Chart for RCMP Subpoena for Written Evidence" (7 March 2022): COMM0063030 at p 41.
12. RCMP H Division Responses to June 2, 2022 Subpoena for Written Evidence": COMM0059949 at p 3.
13. Mass Casualty Commission, Transcript of Proceedings [27 September 2022] at 50 lines 7–8: COMM006509
14. Mass Casualty Commission, "Transcript of Recorded Interview of Chris Leather" (6 July 2022): COMM0059832 at p 106.
15. Mass Casualty Commission, "Transcript of Recorded Interview of Costa Dimopoulos" (30 August 2022): COMM0063690 at p 12.
16. Mass Casualty Commission, "Transcript of Proceedings of A/Commr. Lee Bergerman," (22 August 2022): COMM0063188 at p 21–22.

17. Email from Derek Santosuosso to Amanda Doyle et al, "Issues Management Team Mandate" (4 May 2020): COMM0037383 at pp 1–2.
18. Mass Casualty Commission, "Transcript of Recorded Interview of Costa Dimopoulos" (30 August 2022): COMM0063690 at p 11.
19. Mass Casualty Commission, "Transcript of Recorded Interview of Costa Dimopoulos" (30 August 2022): COMM0063690 at p 54.
20. Mass Casualty Commission "Transcript of Recorded Interview of Costa Dimopoulos" (30 August 2022): COMM0063690 at pp 51–52.
21. Letter from Minister Mark Furey to Assistant Comm. Lee Bergerman (28 October 2020): COMM0064523.
22. Letter from Minister Mark Furey to Assistant Comm. Lee Bergerman (11 December 2020): COMM0064526.
23. "RCMP H Division Response to June 2, 2022 Subpoena for Written Evidence": COMM0059949 at p 4.
24. Minister Mark L. Furey, "Response to MCC Questions" (22 August 2022): COMM006369 at p 10.
25. Minister Mark L. Furey, "Response to MCC Questions" (22 August 2022): COMM0063694 at p 10.
26. Mass Casualty Commission, "Recorded Interview of Deputy Commissioner Brian Brennan," (10 August 2022): COMM0063046 at p 24.
27. Mass Casualty Commission "Transcript of Recorded Interview of Costa Dimopoulos" (30 August 2022): COMM0063690 at p 13.
28. Email from Dustine Rodier to Chris Leather, "Re: Fwd: Request for Urgent Review: BN to PS MIN ALERT READY 2020-0393" (1 May 2020): COMM0033987.
29. Email from Dustine Rodier to Derek Santosuosso, Glen Byrne, Darryl Macdonald, and Costa Dimopoulos "FW: H Division OCC Business Continuity Plan 2019" (1 May 2020): COMM0028505 at pp 1–2 .
30. Mass Casualty Commission, Transcript of Proceedings, 7 June 2022: COMM0058970 at p 84 lines 1–4.
31. Briefing note to Chief Dan Kinsella and C/Supt. Janis Gray from Insp. Greg Robertson, "Impact of Alert Ready on Integrated Emegerncy Services Communication Centre" (27 April 2020): COMM0033958.
32. Briefing note to Chief Dan Kinsella and C/Supt. Janis Gray from Insp. Greg Robertson, "Impact of Alert Ready on Integrated Emergency Services Communication Centre" (27 April 2020): COMM0033958 at p 5.
33. Briefing note to Chief Dan Kinsella and C/Supt. Janis Gray from Insp. Greg Robertson, "Impact of Alert Ready on Integrated Emegerncy Services Communication Centre" (27 April 2020): COMM0033958.
34. Briefing note to Chief Dan Kinsella and C/Supt. Janis Gray from Insp. Greg Robertson, "Impact of Alert Ready on Integrated Emegerncy Services Communication Centre" (27 April 2020): COMM0033958 at p 5.

35. RCMP Situation Report, "RCMP Use of the Alert Ready System" (7 May 2020): COMM0050263 at p 1. This Situation Report also notes that those calls would have been "delayed."
36. Mass Casualty Commission, "Public Communications from the RCMP and Governments about the Mass Casualy: Appendix of Press Briefing Transcripts" (10 May 2022): COMM0057762 at p 72.
37. RCMP, "Risk Analysis and Mitigation Strategy Related to Activation of the Nova Scotia Public Alerting System" (9 May 2022): COMM0058467 ["KPMG Report"].
38. Mass Casualty Commission, Transcript of Proceedings, June 9 2022: COMM0058950 at p 176 lines 25–27.
39. RCMP, "Risk Analysis and Mitigation Strategy Related to Activation of the Nova Scotia Public Alerting System" (9 May 2022): COMM0058467 at p 3 ["KPMG Report"].
40. RCMP, "Risk Analysis and Mitigation Strategy Related to Activation of the Nova Scotia Public Alerting System" (9 May 2022): COMM0058467 at p 33 ["KPMG Report"].
41. RCMP, "Risk Analysis and Mitigation Strategy Related to Activation of the Nova Scotia Public Alerting System" (9 May 2022): COMM0058467 at p 58 ["KPMG Report"].
42. RCMP, "Risk Analysis and Mitigation Strategy Related to Activation of the Nova Scotia Public Alerting System" (9 May 2022): COMM0058467 at p 60 ["KPMG Report"].
43. RCMP, "Risk Analysis and Mitigation Strategy Related to Activation of the Nova Scotia Public Alerting System" (9 May 2022): COMM0058467 at p 3 ["KPMG Report"].
44. RCMP, "Risk Analysis and Mitigation Strategy Related to Activation of the Nova Scotia Public Alerting System" (9 May 2022): COMM0058467 at p 4 ["KPMG Report"].
45. Mass Casualty Commission interview of Chief David MacNeil: COMM0003767 at p 119.
46. Mass Casualty Commission interview of Chief Robert Walsh: COMM0064904 at p 13.
47. Mass Casualty Commission Interview of Julia Cecchetto: COMM0015891 at p7.
48. Response to Subpoena of Halifax Regional Police Chief Dan Kinsella, July 14, 2022: COMM0061317 at pp 15–16.
49. Mass Casualty Commission, Transcript of Proceedings, June 6, 2022: COMM0058947 at p 59 lines 22–23. ["MacNeil Testimony]. He also confirmed this evidence on questioning by participants' counsel (MacNeil Testimony, at p 183 lines 13–24).
50. Mass Casualty Commission interview of Chief David MacNeil: COMM0003767 at pp 119–20.
51. Mass Casualty Commission interview of the Honourable Mark I. Furey: COMM0065058 at p 21.
52. Mass Casualty Commission interview of the Honourable Mark I. Furey: COMM0065058 at p 2
53. Mass Casualty Commission interview of the Honourable Mark I. Furey: COMM0065058 at p 21.
54. Mass Casualty Commission interview of A/Comm. Lee Bergerman: COMM0062441 at p 106.
55. Mass Casualty Commission interview of C/Supt. Janis Gray: COMM0059587 at p 4
56. Mass Casualty Commission interview of C/Supt. Chris Leather (July 6 2022): COMM0059832 at p 121.

57. Mass Casualty Commission interview of C/Supt. Chris Leather (July 6 2022): COMM0059832 at pp 118–19.
58. Mass Casualty Commission interview of C/Supt. Chris Leather (July 6 2022): COMM0059832 at p 11
59. Mass Casualty Commission, Transcript of Proceedings, July 27 2022: COMM0061294 at p 139 lines 25–2
60. Mass Casualty Commission, Transcript of Proceedings, July 27 2022: COMM0061294 at pp 139 lines 16–28, 140 lines 1–
61. CISNS Intelligence Bulletin, May 4, 2011: COMM0006667.
62. Mass Casualty Commission, Transcript of Recorded interview of Chief D. MacNeil, August 3, 2021 at p 112: COMM0003767 at p 112; see also Mass Casualty Commission, Transcript of Proceedings, June 6, 2022: COMM0058947 at pp 49–50.
63. Mass Casualty Commission, Transcript of Proceedings, June 6, 2022: COMM0058947 at 183.
64. Mass Casualty Commission, Transcript of Proceedings, June 6, 2022: COMM0058947 at 183.
65. Mass Casualty Commission, Transcript of Recorded Interview of C/Supt. C. Leather, July 6, 2022: COMM0059832 at p 113.
66. Mass Casulty Commission, Transcript of Proceedings, July 27, 2022: COMM0061294 at p 142.
67. Mass Casulty Commission, Transcript of Proceedings, July 28, 2022: COMM0061295 at p 115.
68. Royal Canadian Mounted Police Member's Handwritten Notes, [May 12, 2020]: COMM0062686 at pp 14–15; Royal Canadian Mounted Police Member's Handwritten Notes, [May 12, 2020]: COMM0058648 at pp 10–11.
69. Mass Casualty Commission, Transcript of Recorded Interview of Supt. C. Dimopoulos, August 30, 2022: COMM0063690 at p 53.
70. Mass Casualty Commission, Transcript of Proceedings, September 9, 2022: COMM0064848 at p 17.
71. Mass Casualty Commission, Transcript of Proceedings, September 9, 2022: COMM0064848 at p 18.
72. Mass Casualty Commission, Transcript of Recorded Interview of Supt. C. Dimopoulos, August 30, 2022: COMM0063690 at p 55.
73. Mass Casualty Commission, Transcript of Recorded Interview of Supt. C. Dimopoulos, August 30, 2022: COMM0063690 at p 67.
74. RCMP, Notes related to Discussion on Issues Management – CISNS Bulletin, May 14, 2020: COMM0028889 at pp 3–4.
75. RCMP, Notes related to Discussion on Issues Management – CISNS Bulletin, May 14, 2020 at p 4,7: COMM0028889.
76. Mass Casualty Commission, Transcript of Recorded Interview of Supt. D. Campbell, July 25, 2022: COMM0061287 at p 95.
77. Mass Casualty Commission, Transcript of Recorded Interview of C/Supt. C. Leather, July 6, 2022: COMM0059832 at p 116.
78. RCMP, "H" Division Issues Management Team (IMT) – Officer Safety Bulletin, May 26, 2020: COMM0018144 at p 7.

79. RCMP, "H" Division Issues Management Team (IMT) – Officer Safety Bulletin, May 26, 2020: COMM0018144 at p 7.
80. Email from C/Supt. C. Leather (RCMP) to D. Pike (Amherst), D. Kinsella (Halifax) and D. MacNeil (Truro) dated May 26, 2020: COMM0018234 at p 3.
81. Email from C/Supt. C. Leather (RCMP) to D. Pike (Amherst), D. Kinsella (Halifax) and D. MacNeil (Truro) dated May 26, 2020: COMM0018234 at p 2.
82. Email from C/Supt. C. Leather (RCMP) to D. Pike (Amherst), D. Kinsella (Halifax) and D. MacNeil (Truro) dated May 26, 2020: COMM0018234 at p 2.
83. Email from C/Supt. C. Leather (RCMP) to D. Pike (Amherst), D. Kinsella (Halifax) and D. MacNeil (Truro) dated May 26, 2020: COMM0018234 at p 2.
84. Email from C/Supt. C. Leather (RCMP) to D. Pike (Amherst), D. Kinsella (Halifax) and D. MacNeil (Truro) dated May 26, 2020: COMM0018234 at p 1.
85. Email from C/Supt. C. Leather (RCMP) to D. Pike (Amherst), D. Kinsella (Halifax) and D. MacNeil (Truro) dated June 2, 2020: COMM0061352 at p 1.
86. Email from C/Supt. C. Leather (RCMP) to D. Pike (Amherst), D. Kinsella (Halifax) and D. MacNeil (Truro) dated June 2, 2020: COMM0061352 at p 1.
87. Email from D. Kinsella (Halifax) to C/Supt. C. Leather (RCMP), D. Pike (Amherst), and D. MacNeil (Truro) dated June 3, 2020: COMM0061352.
88. Halifax Regional Police Response to Chief Dan Kinsella's Subpoena, July 27, 2022: COMM0061317 at p 17.
89. Mass Casualty Commission, Transcript of Recorded Interview of Chief D. MacNeil, August 3, 2021: COMM0003767 at pp 112–13.
90. Mass Casualty Commission, Transcript of Recorded Interview of Chief D. Pike, January 18, 2022: COMM0051442 at p 86.
91. Mass Casualty Commission, Transcript of Recorded Interview of Chief D. Pike, January 18, 2022: COMM0051442 at p 86.
92. Mass Casualty Commission, Transcript of Proceedings, July 27, 2022: COMM0061294 at p 140.
93. Mass Casualty Commission, Transcript of Proceedings, July 27, 2022: COMM0061294 at p 140.
94. Mass Casualty Commission, Transcript of Proceedings, July 27, 2022: COMM0061294 at p 139.
95. Mass Casualty Commission, Transcript of Recorded Interview of Supt. C. Dimopoulos, August 30, 2022: COMM0063690 at pp 65–66.
96. Mass Casualty Commission, Transcript of Recorded Interview of Supt. C. Dimopoulos, August 30, 2022: COMM0063690 at p 66.
97. Mass Casualty Commission, Transcript of Recorded Interview of Supt. C. Dimopoulos, August 30, 2022: COMM0063690 at p 66.
98. Mass Casualty Commission, Transcript of Recorded Interview of Supt. C. Dimopoulos, August 30, 2022: COMM0063690 at p 74.

CHAPTER 8

Involvement of the Serious Incident Response Team in the Post-Crisis Period

1. *Police Act*, SNS 2004, c 31, s 2(l).
2. *Police Act*, SNS 2004, c 31, s 26D(b
3. *Attorney General of the Province of Quebec and Keable v Attorney General of Canada*, [1979] 1 SCR 218; 90 DLR (3d) 161, at para 2
4. "SiRT File # 2020-016 RCMP April 20, 2020," Serious Incident Response Team, April 9, 2021: COMM0017955 at p 524.
5. Donald Stienburg, "Email to Andrew Mathews and Richard Lane," Royal Canadian Mounted Police, April 29, 2020: COMM0061345 at p 2.
6. "Can Say Statement of Staff Sgt Don Stienburg," Halifax Regional Police, April 27, 2020: COMM0009978 at p 2.
7. HRM Police, "General Occurrence Hardcopy (Assist Other Agency – Police) GO# HP 2020-47414": COMM0014868 at p 162.
8. *Serious Incident Response Team Regulations*, NS Reg 89/2012, s 4.
9. RCMP, H Division *Operational Manual*, "54.1. RCMP External Investigation or Review" (March 25, 2019) s 2.6 at 2: COMM0040369.
10. Article 5 also requires the RCMP to "take steps to ensure compliance with regulations under the *Police Act* regarding the separation of officers in all matters identified as Serious Incidents." See: "Memorandum of Understanding Between Nova Scotia Serious Incident Response Team And 'H' Division Royal Canadian Mounted Police," July 30, 2013, 5(a) and 5(b): COMM005960
11. "Memorandum of Understanding Between Nova Scotia Serious Incident Response Team And 'H' Division Royal Canadian Mounted Police," July 30, 2013, 7(f): COMM005960
12. "Memorandum of Understanding Between Nova Scotia Serious Incident Response Team And 'H' Division Royal Canadian Mounted Police," July 30, 2013, 7(b): COMM005960
13. RCMP, *Operational Manual*, "ch. 54.1. RCMP External Investigation or Review" (September 28, 2017) s 9.1.6: COMM0058879 at p 72
14. Mass Casualty Commission, "Transcript of Recorded Interview of Janis Gray" (June 22, 2022): COMM0059587 at pp 64–65.
15. Mass Casualty Commission, "Transcript of Recorded Interview of Felix Cacchione" (September 9, 2022) at 22: COMM0064899 at p 22.
16. Mass Casualty Commission, "Transcript of Recorded Interview of Chris Leathe" (July 6, 2022): COMM0059832 at p 77.
17. Mass Casualty Commission, "Transcript of Recorded Interview of Pat Curran" (September 2, 2022): COMM0065185 at p 18.
18. Mass Casualty Commission, "Transcript of Recorded Interview of Pat Curra" (September 2, 2022): COMM0065185 at p 19.
19. Mass Casualty Commission, "Transcript of Recorded Interview of Pat Curran" (September 2, 2022): COMM0065185 at p 16.

20. Mass Casualty Commission, Transcript of Proceedings, July 22, 2021: COMM0061292 at p 10 lines 8–9.
21. Mass Casualty Commission, Transcript of Proceedings, July 22, 2021: COMM0061292 at p 10 lines 17 and 19–21.
22. Mass Casualty Commission, "Transcript of Recorded Interview of Felix Cacchione" (September 9, 2022): COMM0064899 at p 22.
23. 48. RCMP, H Division Operational Manual, "54.1. RCMP External Investigation or Review" (March 25, 2019) ss 2.5.1 and 2.6.1–2.6.2.1 at p 2: COMM004036
24. *Serious Incident Response Team Regulations*, NS Reg 89/2012, s
25. *Serious Incident Response Team Regulations*, NS Reg 89/2012, s 5(2
26. Mass Casualty Commission, Transcript of Proceedings, May 5, 2022: COMM0057389 at p 94 line 6.
27. Serious Incident Response Team, "SiRT File # 2020-016 RCMP April 20, 2020," April 9, 2021: COMM0017955 at p 525.
28. Rob Bell, "Handwritten Notes of Rob Bell," April 19, 2020, at 34: COMM0014558 at p 34.
29. Mass Casualty Commission, "Transcript of Recorded Interview of Rob Bell" (August 15, 2022) at 61: COMM0063024 at p 61.
30. Rob Bell, "Handwritten Notes of Rob Bell," April 19, 2020: COMM0014558 at pp 10 and 34–35.
31. Serious Incident Response Team, "SiRT File # 2020-016 RCMP April 20, 2020," April 9, 2021: COMM0017955 at p 526.
32. Rob Bell, "Handwritten Notes of Rob Bell," April 19, 2020: COMM0014558 at pp 10, 35.
33. Allan Carroll, "Handwritten Notes of Allan Carroll," April 19, 2020: COMM0013915 at p 13.
34. Serious Incident Response Team, "SiRT File # 2020-017 RCMP April 19, 2020," April 27, 2021: COMM0017877 at pp 153–54.
35. Serious Incident Response Team, "SiRT File # 2020-017 RCMP April 19, 2020," April 27, 2021: COMM0017877 at p 154.
36. RCMP, H Division *Operational Manual*, "54.1. RCMP External Investigation or Review" (March 25, 2019) ss 3.1.5 at p 3: COMM004036
37. RCMP, H Division *Operational Manual*, "54.1. RCMP External Investigation or Review" (March 25, 2019) s 6.1.1 at p 4: COMM004036
38. Serious Incident Response Team, "Annual Report 2020–2021" (May 31, 2022), at p 4, online: https://sirt.novascotia.ca/sites/default/files/reports/Annual%20Report_2020-2021.pdf.
39. Mass Casualty Commission, Transcript of Proceedings, September 14, 2022: COMM0064774 at p 98 lines 11–15.
40. The Hon. Michael H. Tulloch, *Report of the Independent Police Oversight Review* (Ontario, Queen's Printer, 2017): COMM0058298 at p 74.
41. Mass Casualty Commission, "Transcript of Recorded Interview of Pat Curran" (September 2, 2022): COMM0065185 at p 14.

42. The Hon. Michael H. Tulloch, *Report of the Independent Police Oversight Review* (Ontario, Queen's Printer, 2017): COMM0058298 at p 130.
43. Serious Incident Response Team, "Summary of Investigation: SiRT File # 2020-016 RCMP April 19, 2020," December 15, 2020: COMM0052826 at p 2.
44. Sandra L. McCulloch et al, "Final Written Submissions of Patterson Law," October 7, 2022, at p 2
45. Mass Casualty Commission, Transcript of Proceedings, June 6, 2022: COMM0058947 at p 213 lines 7–11.
46. The Hon. Michael H. Tulloch, *Report of the Independent Police Oversight Review* (Ontario, Queen's Printer, 2017): COMM0058298 at p 121.
47. Mass Casualty Commission, "Transcript of Recorded Interview of Felix Cacchione" (September 9, 2022): COMM0064899 at p 47.
48. Mass Casualty Commission, "Transcript of Recorded Interview of Pat Curran" (September 2, 2022): COMM0065185 at p 4.
49. Mass Casualty Commission, "Transcript of Recorded Interview of Pat Curran" (September 2, 2022): COMM0065185 at p 4.
50. Memorandum of Understanding Between Nova Scotia SiRT and 'H' Division RCMP (30 July 2013): COMM0059606 at p 2.
51. Memorandum of Understanding Between Nova Scotia SiRT and 'H' Division RCMP (30 July 2013), Art 4(f): COMM0059606 at p 3.
52. Serious Incident Response Team, Onslow SiRT Report prepared by SiRT (19 April 2020): COMM0017877 at p 174.
53. Mass Casualty Commission, Transcript of Recorded Interview of Pat Curran: COMM0065185 at p 40.
54. Mass Casualty Commission, Transcript of Recorded Interview of Pat Curran: COMM0065185 at p 40.
55. Mass Casualty Commission, Transcript of Recorded Interview of Pat Curran: COMM0065185 at p 40.
56. Mass Casualty Commission, Transcript of Proceedings, 28 July 2022: COMM0061295 at p 37 lines 10–11 [C/Supt. Chris Leather].
57. Mass Casualty Commission, Transcript of Recorded Interview of Chris Leather: COMM0059832 at p 139 ; Mass Casualty Commission, Transcript of Proceedings, 28 July 2022: COMM0061295 at p 33 lines 1–5 [C/Supt. Chris Leather].
58. Serious Incident Response Team, Onslow SiRT Report prepared by SiRT (19 April 2020): COMM0017877 at p 161.
59. Serious Incident Response Team, Onslow SiRT Report prepared by SiRT (19 April 2020): COMM0017877 at p 162.
60. Mass Casualty Commission, Transcript of Recorded Interview of Pat Curran: COMM0065185 at p 38.
61. Mass Casualty Commission, Transcript of Recorded Interview of Pat Curran: COMM0065185 at p 38.

62. H Division, *Operation Manual* (25 March 2019): COMM0040369 at Ch 54.1 s 2.5.
63. Mass Casualty Commission, Transcript of Recorded Interview of Pat Curran: COMM0065185 at p 42.
64. Notes of C/Supt. John Robin (2 December 2020 – 28 March 2021): COMM0063685 at p 32. Also Hovey Investigative Log COMM0017877, p 178, states "Bobbie Haynes sent me an email version of what was discussed in the teleconference" (COMM0017877 at p 178).
65. Mass Casualty Commission, Transcript of Recorded Interview of Felix Cacchione: COMM0064899 at p 34.
66. Memorandum on Use of Force Report prepared by S/Sgt. Bobbie Haynes (18 January 2021): COMM0017903 at p 1.
67. Memorandum on Use of Force Report prepared by S/Sgt. Bobbie Haynes (18 January 2021): COMM0017903 at p 5.
68. Mass Casualty Commission, Transcript of Recorded Interview of Felix Cacchione: COMM0064899 at p 30.
69. Mass Casualty Commission, Transcript of Recorded Interview of Felix Cacchione: COMM0064899 at p 29.
70. Serious Incident Response Team, Onslow SiRT Report prepared by SiRT (19 April 2020): COMM0017877 at p 253.
71. Email from Todd Brown to SiRT (5 March 2021): COMM0065560.
72. Email from Todd Brown to SiRT (5 March 2021): COMM0065560.
73. Email from Felix Cacchione to C/Supt. Chris Leather (9 March 2021): COMM0065548.
74. Notes of C/Supt. John Robin (2 December 2020 – 28 March 2021): COMM0063686 at pp 32–34. Meeting was sometime between March 12 and 14, 2020 – precise date unclear due to DOJ redactions in C/Supt. Robin's notebook.
75. Mass Casualty Commission, Transcript of Recorded Interview of Felix Cacchione: COMM0064899 at pp 35–36.
76. Mass Casualty Commission, Transcript of Recorded Interview of Chris Leather: COMM0065199 at p 36.
77. Mass Casualty Commission, Transcript of Recorded Interview of Chris Leather: COMM0065199 at p 36.
78. Mass Casualty Commission, Transcript of Recorded Interview of Chris Leather: COMM0065199 at p 36.
79. Mass Casualty Commission, Transcript of Recorded Interview of Chris Leather: COMM0065199 at pp 7–8.
80. Mass Casualty Commission, Transcript of Recorded Interview of Chris Leather: COMM0065199 at p 8.
81. Mass Casualty Commission, Transcript of Recorded Interview of Chris Leather: COMM0065199 at p 8.
82. Mass Casualty Commission, Transcript of Recorded Interview of Chris Leather: COMM0065199 at p 11.

83. Mass Casualty Commission, Transcript of Recorded Interview of Chris Leather: COMM0065199 at p 8.
84. Mass Casualty Commission, Transcript of Recorded Interview of Chris Leather: COMM0065199 at p 8.
85. Mass Casualty Commission, Transcript of Recorded Interview of Chris Leather: COMM0065199 at p 8.
86. Mass Casualty Commission, Transcript of Recorded Interview of Chris Leather: COMM0065199 at p 8.
87. Mass Casualty Commission, Transcript of Recorded Interview of Chris Leather: COMM0065199 at pp 8–9.
88. Mass Casualty Commission, Transcript of Recorded Interview of Costa Dimopoulos: COMM0063690 at pp 104–5.
89. Mass Casualty Commission, Transcript of Recorded Interview of Costa Dimopoulos: COMM0063690 at p 104.
90. Mass Casualty Commission, Transcript of Recorded Interview of Costa Dimopoulos: COMM0063690 at p 104.
91. Mass Casualty Commission, Transcript of Recorded Interview of Chris Leather: COMM0065199 at p 9.
92. Mass Casualty Commission, Transcript of Recorded Interview of Chris Leather: COMM0065199 at p 10.
93. Mass Casualty Commission, Transcript of Recorded Interview of Felix Cacchione: COMM0064899 at p 41.
94. SiRT Referral Email from C/Supt. Leather to Felix Cacchione (24 July 2020): COMM0065151.
95. Notes of C/Supt. Chris Leather (7 July 2020–27 July 2020): COMM0065182 at p 6.
96. Mass Casualty Commission, Transcript of Recorded Interview of Chris Leather: COMM0065199 at pp 12–13.
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PART C: REIMAGINING POLICING IN CANADA

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PART D: EVERYDAY POLICING PRACTICES

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