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

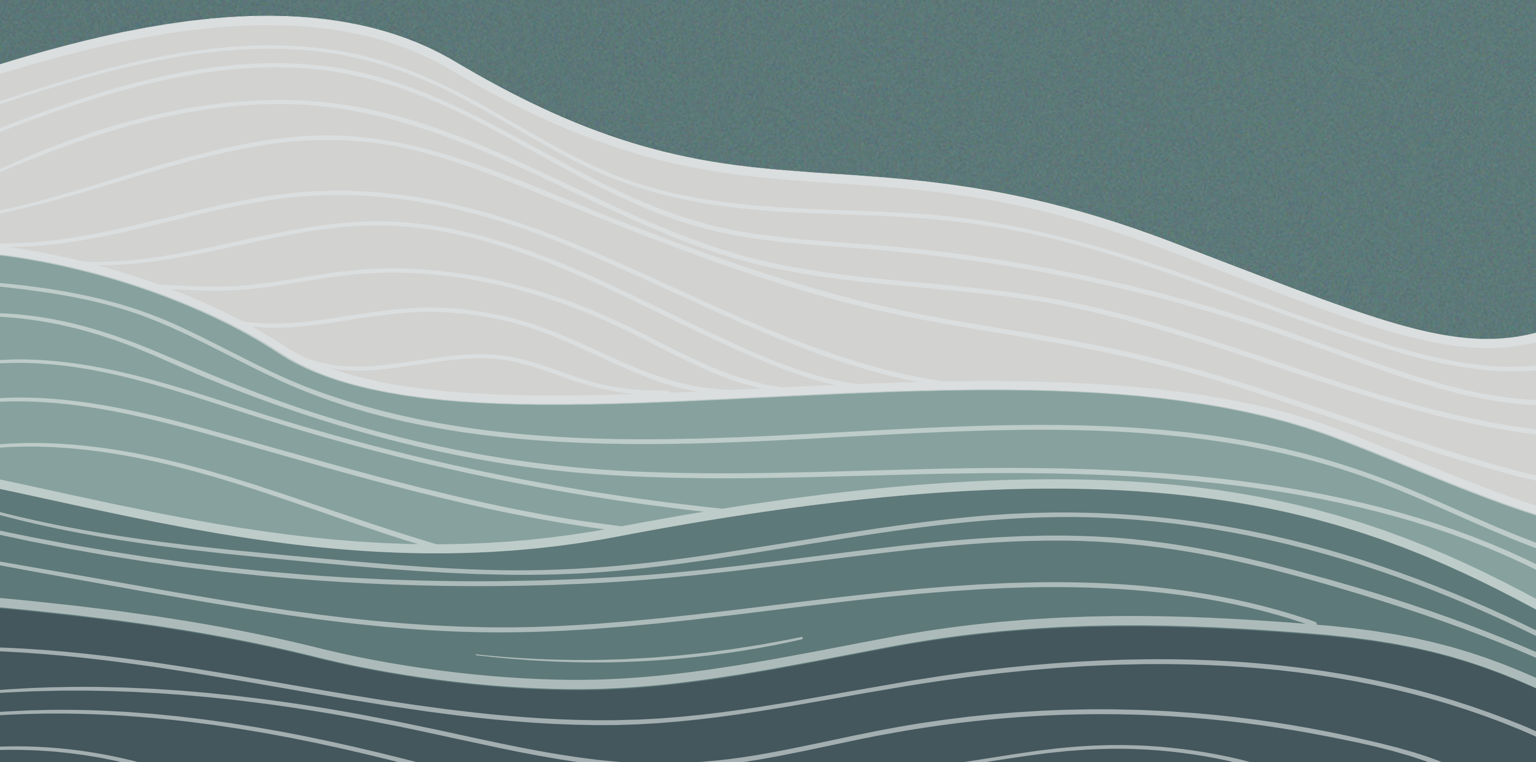
MASS CASUALTY COMMISSION

Turning the Tide Together

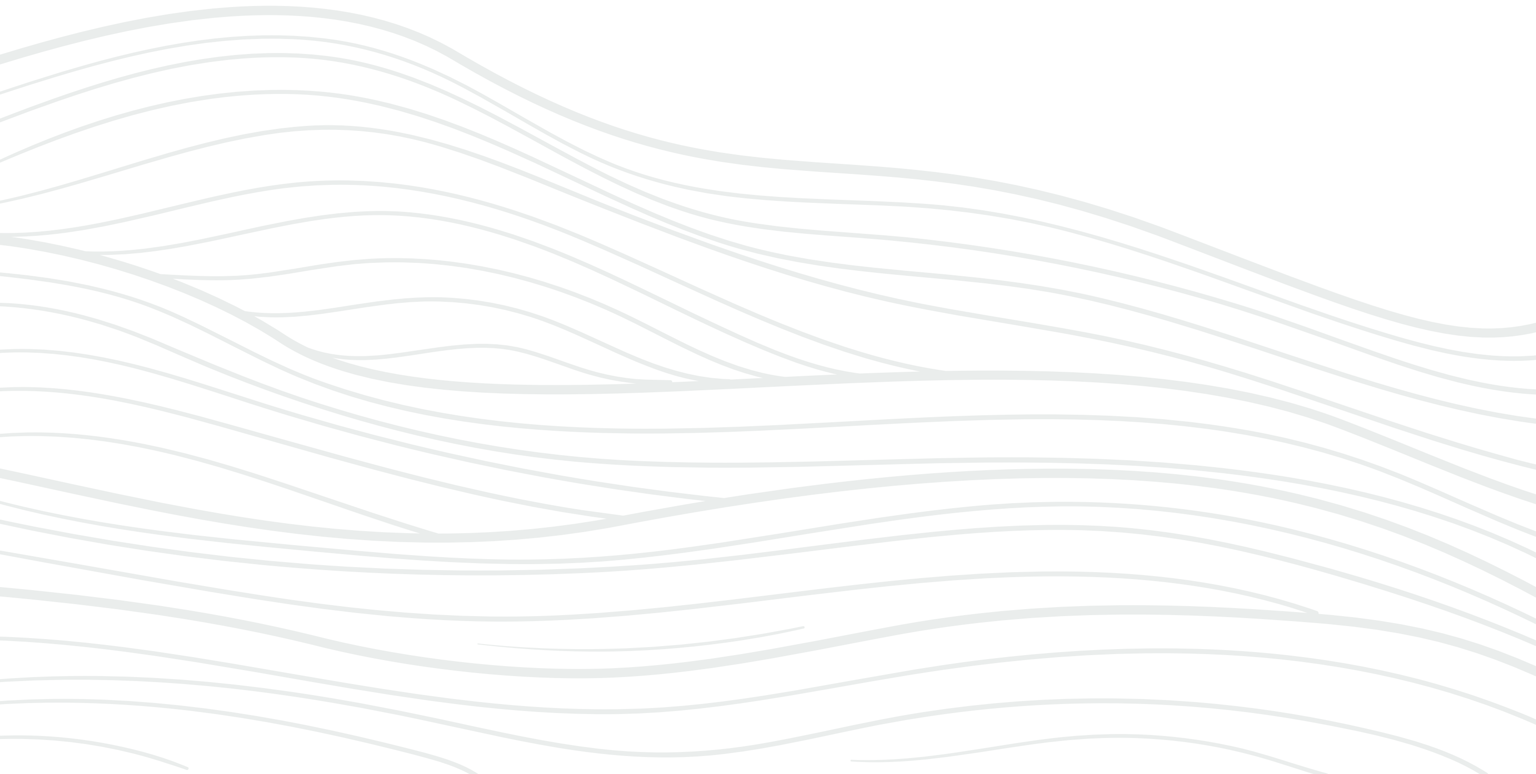
FINAL REPORT OF THE MASS CASUALTY COMMISSION

Volume 7

Process



Turning the Tide Together



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 7

Process

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

Turning the Tide Together:
Final Report of the Mass Casualty Commission
Volume 7: Process

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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 at https://MassCasualtyCommission.ca (English) and https://commissiondespertesmassives.ca (French) 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

CHAPTER 1

Introduction: Purpose of the Process Volume

CHAPTER 1 Introduction: Purpose of the Process Volume

In this volume, we describe the various processes involved in leading and designing the Mass Casualty Commission. The mass casualty of April 18 and 19, 2020, created profound grief, disruption, and destabilization in Nova Scotia and beyond. Early in our mandate, the Commission adopted the image and metaphor of rippled water to signify the breadth and depth of the impact of what happened over approximately 13 hours on April 18 to April 19, 2020, and in the aftermath. The ripple acknowledges that the immediate impact experienced by those most affected – the individuals, families, first responders, service providers, and local communities – was appropriately the starting point of our mandate. It also captures the dynamic impact of the mass casualty, which expanded outward and affected communities, institutions, and society in Nova Scotia, across Canada, in the United States, and further afield.

The Commission saw every day how the mass casualty was a source of grief, bereavement, and trauma for many individuals, families, and communities. Some members of the Commission staff and their families live in Colchester, Cumberland, or Hants counties as well as throughout Nova Scotia. While acknowledging the unique nature and depth of loss for those whose loved ones were taken, regardless of where we live, the mass casualty to varying degrees affected everyone's sense of safety, trust, and well-being. That impact will continue long past the conclusion of our mandate.

As Commissioners, we were motivated by a desire to ensure that our collective work would provide answers and make positive contributions to community safety and well-being in the future. From our first days on the job we made a series of decisions about how best to carry out our mandate with the public interest at the forefront. In line with and throughout our mandate, we invited and endeavoured to seek and respond to input from directly affected Participants in the Commission's process, while maintaining our independence. The mandate also directed that we not express any conclusion or recommendation regarding the civil or criminal

liability of any person or organization. This direction was not unique to our Inquiry; the Supreme Court of Canada has made clear that all public inquiries are prohibited by law from making any findings or conclusions regarding civil and criminal liability.[1] We therefore continually stated that a public inquiry is not a trial; rather than looking to lay blame on individuals, an inquiry is tasked with learning how things can be done better in the future. We operated within the constraints imposed by budget and a prescribed time frame, as well as unprecedented restrictions caused by the COVID-19 pandemic, among other factors beyond our control.

This volume provides a comprehensive record of the steps we took and the reasons behind them. Understanding how we carried out our mandate provides a backdrop to the factual findings, lessons learned, and recommendations detailed in the other volumes. Our process allowed us to hear from many people, including those deeply traumatized by the mass casualty. In turn, we were able to explore factual questions and potential recommendations with careful attention to differing perspectives. We kept people who were engaged in the Inquiry's work informed of our steps and decisions as we went along. Although it is not necessary to read this volume in order to understand the other volumes of this Report, we believe it provides context on how information was gathered and why we took each approach. Our added purpose in setting out those steps and decisions in detail here is to provide assistance to future inquiries.

A central feature of every public inquiry is the ability to design practices and procedures that best suit the issues to be explored. Each public inquiry is unique in terms of mandates, timelines, and other factors, but all share the common challenge of having to create a temporary organizational structure from the ground up that will operate effectively and efficiently in the public's best interest. Many inquiries also have common features in their practices, procedures, rules, and modes of conducting the inquiry. Once we were appointed, we spoke with former commissioners to benefit from their insights and experiences and consulted past reports and relevant texts[2] to see how previous inquiries operated and the lessons they learned. This exercise was enormously helpful, and we hope the following chapters will similarly benefit future commissions.

We also made use of innovative mechanisms in order to manage the large mandate within the two years allotted, in the context of the global COVID-19 pandemic. We knew innovation was required to accomplish our task, which required us to address complex social issues that have challenged our country long before the mass casualty. To that end, we adopted and adapted mechanisms used in previous inquiries,

such as foundational documents and roundtables, to fit our mandate, timeline, and process.

As Commissioners, we were bound to the directions provided to us in the Orders in Council by both Canada and Nova Scotia (Appendix A). Those Orders required us to conduct a comprehensive public inquiry to determine what happened and to make recommendations to avoid such events in future. The Orders required us to consider a wide range of causes, context, and circumstances, beyond the immediate ones that would most directly be of interest to the families. So although we grounded our work each and every day in the memory of those whose lives were taken, and diligently sought to answer the questions the families had about their loved ones, we were required to conduct a public inquiry as directed by the Orders in Council.

Overview of the Volume

There are seven chapters in this volume. Following this introductory chapter, Chapter 2, "Establishing the Mass Casualty Commission," explains the genesis of the Commission and the mandate it received from the Governments of Canada and Nova Scotia that defined its parameters. We also provide general information about the nature and role of public inquiries. Both the public pressure that led to the Commission's establishment and its mandate "to be guided by restorative principles in order to do no further harm"[3] are important contextual factors underlying our work. These principles were to guide the process but did not limit or shape its purpose (in getting to the truth of what happened) nor its goal (to make recommendations for the future). So while restorative principles guided our work, they were not an end in themselves.

In Chapter 3, "Designing the Inquiry," we discuss the logistics of getting the Commission off the ground. We share how we benefited from early consultation with individuals who have expertise working on public inquiries, where we chose to establish our offices, and our approach to hiring staff. We also introduce the individuals and groups who engaged in the Commission's process as Participants, and we explain what that role entails. We then provide information about rules we developed in consultation with Participants to guide our process, and

how we supported participation and public engagement throughout our mandate. We explain how we implemented communications through dedicated efforts to engage the public, including how we worked with the media, in that public engagement. We also consider the impact of the COVID-19 pandemic on the Inquiry and offer some thoughts on the Interim Report.

Chapter 4, "Our Work: Three Phases," introduces the framework we developed to guide our public proceedings and how we put our design into action. In the "Phase 1: Building the Core Evidentiary Foundation" section of this chapter, we detail our approach to establishing the facts of what happened on April 18 and 19, 2020, as well a0s our Phase 1 public proceedings.

"Phase 2: Examining Causes, Context, and Circumstances," explains the steps we took to better understand the facts we had established in Phase 1. It introduces the themes and issues that guided us as the Commission sought to understand how and why the mass casualty occurred, including our three foundational pillars – policing, community, and violence – and how they shaped our Phase 2 public proceedings.

In "Phase 3: Shaping and Sharing," we describe our process of consulting with those most directly affected, with communities, and with stakeholders. The consultations offered an opportunity for us to hear about proposed recommendations from diverse voices and perspectives. This process was crucial to enable us to develop practical and meaningful recommendations that could be championed and implemented by members of the public, policy-makers, public institutions, community groups, and others at the conclusion of the Commission's mandate.

In Chapter 5, we make some recommendations to assist in the set-up phase of future public inquiries and to ensure they have the necessary tools to fulfill their mandates.

In Chapter 6, we provide information about the Commission's expenditures.

In Chapter 7, "Conclusion," we reflect on our process and make a forward-looking invitation to you, our reader, to take up the Commission's recommendations and be part of the work ahead to secure our community and collective safety and well-being. In this way, we can all contribute to preventing future harms, we can learn from the lessons of the mass casualty, and we can put in place better ways to respond. The conclusion is followed by our acknowledgements of those who contributed to this work.

The appendices to this volume include, among other documents, our Rules of Practice and Procedure, our decisions, and a detailed calendar of our public proceedings. We have also prepared three additional annexes. “Annex A: Sample Documents” contains samples and guiding documents we prepared in the course of our work. These annexed documents provide further insight into our processes that we hope will assist future inquiries. “Annex B: Reports” contains reports commissioned by us as well as reports prepared by our team. “Annex C: Exhibits” contains the full list of materials marked as exhibits by the Commission.

The Nature and Role of Public Inquiries

Public inquiries are often defined by what they are not: civil or criminal trials. The purpose of a civil trial is to settle disputes between opposing parties, while criminal trials establish the guilt or innocence of an accused person. This Commission, like all public inquiries, was prohibited from making findings that could be seen as conclusions of civil or criminal liability. Instead, we investigated the facts in order to lay out a factual foundation to support an understanding of what happened and to inform recommendations for what needs to happen in the future. While public inquiries cannot find civil or criminal liability, they do call for accountability. A narrow focus on liability may detract from – or fail to see – the complexity required for true accountability. Seeking to blame looks backward, rather than looking forward to learn. Public inquiries bring facts to public light in a thorough way that pursues the public’s interest in knowing fully what happened and why.

Another important distinction is that public inquiries employ inquisitorial rather than adversarial processes. In the courtroom, judges play a relatively passive role: listening to the opposing positions taken by the parties, weighing the merits of what they have heard, analyzing the evidence, and drawing conclusions from that evidence. In public inquiries, commissioners play a more active role: directing the process (including investigations and analysis of evidence) to implement the mandate; and actively asking questions of witnesses in the public hearings, at roundtables, and in expert panels. Commissioners, unlike judges, are also responsible for

overseeing staff, such as commission counsel and policy analysts, who assist in discharging the commission's mandate.

In civil trials, counsel for the plaintiffs and the defendants prepare their full case ahead of time and present it to the judge, who then decides the outcome. In criminal trials, the Crown prosecutors and the lawyers for the accused prepare their full case in advance and present it to the judge (or in some cases a judge and jury), who decides whether the accused is guilty of the alleged crime. In public inquiries, however, the incoming information is ongoing, adding to the narrative throughout the process, and the commissioners question witnesses and members of panels at public proceedings, and consider all the information as they prepare their final report and recommendations. Commission counsel play a crucial role in helping the commissioners navigate the volume of information, marshalling the evidence and questioning witnesses. Commission counsel act as an extension of the commissioners to engage in an objective and tenacious pursuit of the truth.

> Civil and criminal proceedings focus on narrow issues between parties or between the state and the accused. Public inquiries, in contrast, have the mandate and power to look beyond narrow sets of facts to seek a deeper understanding of what has transpired and why it happened. They are expected to be less legalistic and more innovative and creative in their information-gathering approaches in order to pursue and achieve their mandates.
> Given the wide variety of issues public inquiries are called upon to address, this adaptability and flexibility allow them to pursue their mandates through processes that fit the scope and nature of the issues into which they are inquiring.

Since a public inquiry is a legal mechanism, it is very difficult for lawyers to step away from the adversarial model that they live and breathe in their professional lives. By "lawyers," we include those hired to work as commission counsel and, indeed, those often appointed as commissioners. But a public inquiry is a unique opportunity to come together to seek answers to a complex societal problem and search for solutions in a constructive way. Governments establish inquiries because they acknowledge that something broader than a singular harm has occurred, and it requires all of us to address the issue on a systemic level. This requires co-operation to diagnose and address the problem. The obligations of those who engage with a public inquiry must accord with the public interest, and

that entails an approach that does not seek to blame individuals or determine a locus of civil or criminal liability. Instead, the focus must be on embracing a desire to learn from what has happened in order to do better in future.

Public inquiries are also more flexible than civil or criminal trials.

> The issues before our Commission were larger than they would be before a court – not simply who did what and when, but broader, systemic issues that helped us to answer the questions of how and why the mass casualty happened.

The Commission also had a greater range of tools and mechanisms to carry out its work and to be creative in designing processes toward this end. In civil and criminal trials, procedural issues and the "burden of proof" (a legal standard that must be met to establish facts as true) are prescribed. In a civil matter, the legal standard to establish facts as true is on a "balance of probabilities" (meaning it is more likely than not to have occurred). And in a criminal trial, it is "beyond a reasonable doubt" (near certainty). Inquiries, in contrast to courts, are not subject to the same procedural rules and strict evidence requirements.[4] Because a public inquiry is not about liability or focused on blame, it can be more open to a larger range of information and evidence that may help to make sense of the matters within its mandate.

This flexibility and openness to information and evidence does not mean that an inquiry is less concerned about truth. The inquisitorial system is an official inquiry to ascertain truth, whereas the adversarial system uses a competitive process between the plaintiff and the defendant, or between the prosecutor and the defence, to determine whether certain facts have been proven to a certain legal standard. The key differences are who guides the search for truth and how the process is shaped. Like trials, public inquiries should be guided by "fairness, compassion, independence, expedition, transparency, and openness, efficiency and effectiveness, and they must employ careful and well-articulated reasoning."[5]

Additionally, public inquiries are "public" by their very nature; they include an important level of public engagement and they are conducted in the public interest. Public inquiries typically face high expectations of openness and transparency from the public and the media.[6] Interest in an inquiry's work by members of the public can act as an accountability mechanism, both for the process and for those institutions that are the subject of its work. **After the inquiry is complete,**

the engaged public, as part of its civic responsibility, has an important role to hold governments and other bodies to account to ensure that they implement the recommendations and to help ensure that improvements are made to the systems that were the subject of the inquiry's mandate.

Unlike courts and tribunals, which are permanent institutions in our justice system, public inquiries are an extraordinary mechanism established for a limited period to deal with institutional and systemic issues. For many individuals, the Mass Casualty Commission was their first contact with a public inquiry. Throughout our mandate, we believed it was important for the people who followed our work in Nova Scotia and beyond to understand the nature and role of public inquiries.

We spoke in a video to provide an overview of public inquiries on our website at the outset of our work in December 2020, and we elaborated on it in our Participation Decision (May 2021), our public update (September 2021), our remarks at the opening of public proceedings (February 2022) and in other statements and rulings.[7] Additional educational information about public inquiries was provided at community open houses, information sessions, on our website and social media for the duration of the Commission.

> A public inquiry is an official independent process uniquely designed to examine issues or events that have had a significant impact on the public. Although public inquiries are established and funded by governments, they operate separately and are independent from the government. This independence means, for example, that while as Commissioners we were appointed by two governments (the federal government and the Nova Scotia government), we selected our own independent team and designed our own process. It was this freedom from control by governments, institutions whose actions are under public scrutiny, and other interested parties that assured the independence of both the process of our Inquiry and the findings and recommendations we made. This independence was essential to serve the public interest by ensuring that our process and our recommendations were not unduly influenced by outside institutions or individuals.[8]

It is particularly important that the government that has set up the public inquiry not retain the power to then instruct or interfere with the inquiry, especially where its own political or other interests are involved in the matter being investigated, as

is often the case, and was the case here. Our mandate asked us to examine governmental and other institutional failures that may have contributed to the harms. As with other public inquiries, the public nature of our Commission further ensured transparency and guaranteed that we operated independently of government and institutions. **A public inquiry is a living process and has been described as "an investigation out loud."**[9] Making the interim and final reports of public inquiries public is another accountability safeguard.

Our Commission's focus, as mandated by our Orders in Council, was to gather the relevant facts of the mass casualty; to better understand its causes, context, circumstances, and impact; and to make recommendations to governments and other institutions for forward-looking reforms. As with other public inquiries, we had powers to ensure we received information from individuals, government, institutions, and organizations relevant to our mandate.[10] For example, we could legally require individuals, governments, institutions, associations, and other organizations and institutions to produce documents and other records. We could also compel witnesses to appear and provide oral evidence before the Commission. These powers typically distinguish public inquiries from reviews and other investigations.

CHAPTER 2

Establishing the Mass Casualty Commission

The Road to This Public Inquiry

The specific history of how and why the Mass Casualty Commission was established has shaped our work. Initially, on July 28, 2020, the Governments of Canada and Nova Scotia announced an independent federal-provincial review of the events of April 18 and 19, 2020. Almost immediately, a public outcry against the review as an insufficient response occurred, led by people among the most affected and their supporters. Families of those whose lives had been taken, individuals who had been injured and their families, and many other individuals and groups placed pressure on the governments and demanded a public inquiry. Their main concerns included that a review would lack the power needed for its work. Public inquiries have the authority to compel institutions and individuals to produce documents and to subpoena witnesses to provide testimony.[1] The public wanted the clarity and transparency that a public inquiry would offer.

The Joint Orders in Council of the federal and provincial governments establishing the Mass Casualty Commission were issued on October 21, 2020 (see Appendix A). Of the three individuals appointed to head the review, two of us stayed on to serve as Commissioners of the Mass Casualty Commission:[2] the Honourable J. Michael MacDonald, the former Chief Justice of Nova Scotia appointed as chair, and Leanne J. Fitch, M.O.M., a retired Fredericton police chief. Pursuant to the Orders in Council, Dr. Kim Stanton was appointed as the third Commissioner.

All public inquiries are followed closely by those most directly affected, but we feel strongly that the important role played by the public in the creation of this Inquiry magnified this sense of public investment and connection. We were reminded of this critical public role every day, as the Commission offices looked onto the Grand Parade, a civic space and historical landmark in downtown Halifax and the site of

some of the demonstrations that led to the Commission's creation. It is also the site of the Fallen Peace Officers' Monument on which is inscribed the name Cst. Heidi Stevenson, whose life was taken during this mass casualty. As Commissioners, we acknowledged the need to earn the public's trust and to recognize the high expectations expressed at our appointment. At the same time, we were mindful that we served the interest of all members of the public, not only the more specific interests of any institutions, organizations, or individuals.

Orders in Council (Our Mandate)

The Commission's mandate was set out under the authority of the Governments of Canada and Nova Scotia in accordance with both federal[3] and provincial[4] public inquiry statutes. The details of the mandate were written in official documents known as Orders in Council. These are legal instruments that governed how the Commission was to carry out its work and the authority it could exercise in doing so. They are the only direction that governments can, and must, give to Commissioners to set the parameters for the work of a public inquiry.

> Orders in council set the terms of reference as well as the expected outcomes, and the time frame within which they must be accomplished. Future commissioners would do well to seek input into the orders in council before agreeing to their appointment. Before issuing the orders in council, governments would benefit from open discussion to reach agreement with commissioners about the draft terms of reference. Those discussions would help to ensure that the scope of the mandate, the requirements, and the timelines are realistic at the outset. All commissions are pressed for time and asked to do a range of things; having a common understanding from the outset of what can be reasonably accomplished will serve everyone involved. In other words, it is important to have clarity about expectations and timelines that are shared and realistic from the outset, rather than to have to seek extensions which have become almost standard as commissioners navigate parameters set for them. We expand upon this point in Chapter 5.

The Commission's mandate assigned us specific and interrelated tasks that not only shaped our work but also let the public know what to expect. The Commission was required to establish what happened leading up to, during, and after the mass casualty of April 18 and 19, 2020, in Nova Scotia. In order to establish what happened, the Orders in Council directed the Commission to examine the causes, context, and circumstances, including several defined issues of how and why the mass casualty occurred. Finally, the Commission was required to produce an Interim Report and a Final Report that included our findings, lessons learned, and recommendations to help keep Canadian communities safer in the future. These three main interrelated functions – "to inquire into what happened and make findings," "to examine related issues," and "to produce a report" – are described in some detail in the Orders in Council. We summarize them here. The Mass Casualty Commission's first function was to inquire into what happened and make findings on:

I. the causes, context, and circumstances giving rise to the April 2020 mass casualty;

II. the responses of police, including the Royal Canadian Mounted Police (RCMP), municipal police forces, the Canada Border Services Agency, the Criminal Intelligence Service Nova Scotia, the Canadian Firearms Program, and the Alert Ready Program; and

III. the steps taken to inform, support, and engage those most affected.

The Commission's second function was to examine issues that contributed and were related to the causes, context, and circumstances giving rise to the mass casualty, including but not limited to the following:

I. contributing and contextual factors, including the role of gender-based and intimate partner violence;

II. access to firearms;

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 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;

IX. policies with respect to the disposal of police vehicles and any associated equipment, kit, and clothing;

X. policies with respect to police response 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.

The Commission's third function was to produce a report that:

> sets out lessons learned as well as recommendations that could help prevent and respond to similar incidents in the future.

It is significant that our Orders in Council directed the Commission to go beyond establishing what happened and to examine and review the full causes, context, and circumstances that gave rise to the mass casualty. **Unlike some inquiries that are limited to fact finding, or others that are focused on policy questions, this Inquiry was explicitly directed to look at the factual exploration in a broader contextual landscape. This direction meant that our task had a larger public policy framework within which we were asked to operate, and it meant our process could not focus solely on one or the other.**

Our Orders in Council also directed us to be guided by restorative principles (as we discuss in detail below) in carrying out our mandate, to take steps to reduce the chances of doing further harm; to be trauma-informed and attentive to the needs of those most directly affected by the mass casualty; and "to give particular

MASS CASUALTY COMMISSION

Our Mandate

MASS CASUALTY COMMISSION
COMMISSION DES PERTES MASSIVES

The Commission's mandate assigns specific tasks to guide its work and to let the public know what to expect.

The Commission is required to **establish what happened** leading up to, during and after the mass casualty of April 18 and 19, 2020 in Nova Scotia. The Commission must also **review certain defined issues** that provide context to understand why and how the mass casualty occurred, including those listed below. Finally, the Commission must **produce a report** that includes these findings, lessons and resulting recommendations to help keep Canadian communities safer in the future.

To view the full mandate as described in the Orders in Council visit **masscasualtycommission.ca/about/mandate**.

① ESTABLISH WHAT HAPPENED	Causes, context and circumstances giving rise to the mass casualty	Emergency responses of police, including RCMP, municipal police forces and the Alert Ready program	Steps taken to inform, support and engage victims, families and affected citizens
② EXPLORE RELATED ISSUES	Communications between and within agencies and services	Communication with the public	Firearms access
	Gender-based and intimate partner violence	Perpetrator interactions and relationship with police and social services	Police actions, policies, procedures, and training
③ PRODUCE A REPORT	Findings, lessons and recommendations		

consideration to any persons or groups who have been differentially impacted by the mass casualty," who, because of their particular circumstances, were affected in different ways. (We explain this terminology below.) The Orders in Council are mandatory directions to the Commissioners and, despite the breadth of the mandate, we could not pick and choose only some parts of them to fulfill. We had to find a way to address every aspect of the mandate.

The Orders in Council authorized us to adopt any procedures and methods we considered expedient for the proper conduct of our work and to consider previous examinations or investigations we deemed relevant to our Inquiry. As noted, our Commission, like all public inquiries, was directed to perform its duties without expressing conclusions or recommendations regarding the civil or criminal liability of any person or organization. We were also responsible for carrying out our work in a way that would not jeopardize "any ongoing criminal investigation or proceeding or any other investigation."

This provision proved to be particularly challenging for us because an important witness, the perpetrator's common law spouse, Lisa Banfield, was charged criminally within weeks of our Orders in Council being issued. The RCMP's treatment of her and investigation of her were connected to the subjects we were mandated to investigate (such as the police response), so their charging her created a challenge for us to fully discharge our mandate in that regard. Understandably, Ms. Banfield felt unable to accept our interview requests while she was in criminal jeopardy. This provision also made it challenging for us to determine if and when we should compel Ms. Banfield's testimony, if there proved no other way of hearing from her. Given the centrality of Ms. Banfield's evidence to so many aspects of our mandate, it would have been preferable to receive the benefit of her considerable co-operation from the outset of the mandate. This provision also limited our ability to explore how the RCMP treated Ms. Banfield during the "H-Strong" investigation. Furthermore, this was not the only additional proceeding affecting our work. A civil class action against Ms. Banfield in the Supreme Court of Nova Scotia filed by the same counsel representing several Participants before us also complicated matters.

Restorative Principles Guiding the Work of the Inquiry

Mass Casualty Commission Terms of Reference: Restorative Principles

The Joint Orders in Council establishing the Commission direct the Commissioners, in carrying out their work,

(e)(i) to be guided by restorative principles in order to do no further harm, be trauma-informed and be attentive to the needs of and impacts on those most directly affected and harmed, and

(e)(ii) to give particular consideration to any persons or groups that may have been differentially impacted by the tragedy.

The Commission's mandate directed us to be guided by restorative principles in carrying out our work. This approach was consistent with other recent commissions[5] and is also consistent with a wide range of initiatives in Nova Scotia that regularly engage restorative principles, as discussed below. However, **being guided by a restorative approach does not change what a public inquiry is required to accomplish**. Rather, it aims to ensure that the work is done with a commitment to understanding human needs in a context where institutions, organizations, or other bodies can be alienating. We were conscious that, despite our best efforts, many decisions we made throughout the course of our mandate had the potential to injure or retraumatize people. **Although our mandate required us to be trauma-informed, we knew that it was only through close and public scrutiny of the mass casualty, its antecedents, and its aftermath that we could develop and share with the public a full understanding of what happened, how it happened, and why it happened. We also knew that building a safer future depends on rebuilding public confidence in the institutions responsible for our safety.** The Orders in Council required that we be guided by restorative principles to help us be attentive to needs – and in this case, particularly aware of and attentive to the trauma that people and communities had experienced. Trauma-informed in this case meant understanding the existing trauma and taking it into account as we pursued our mandate; it could not, and did not, impede our pursuit of the mandate. It *informed* us in order to approach our work in the way that would enable people to participate in the best ways possible to get at the information required.

We approached our work with an awareness that Participants in our process and the communities we were working in had experienced a profound trauma, producing different trauma reactions for everyone. This awareness, combined with the nature of a public inquiry as a flexible process, meant that we were able to create processes, and sometimes adjust them as we went on, to try to minimize the ways the Commission might cause further harm. As described below, we used several approaches to achieve this goal, always with an unwavering commitment to get the facts, answers, and best information, and ultimately to develop our recommendations.

A restorative approach will differ according to the purpose and context in which it is being used, but it is based on a shared set of common principles. These principles are often associated with the criminal justice system[6] and with processes designed to promote repairing relationships and, sometimes, healing. In our mandate to develop an understanding of the events and issues regarding the mass casualty so we could recommend responses to them, restorative principles guided

the work of the Inquiry but did not shape or change its purpose or mandate. If there is an expectation that an inquiry contribute to healing, it would have to be explicit in its mandate and that inclusion would have implications for the design and operation of the commission. That was not how restorative principles were included or approached in our mandate.

For future inquiries, as part of defining their mandates, it may be helpful to provide clarity around who might play a role in leading healing for communities after an event such as a mass casualty. If it occurs as a natural outcome of the inquiry process, that is welcome, but it is important that expectations be managed about the ways in which an inquiry is expected to effect such change.

At the time of our Inquiry, Nova Scotia was lauded for its significant use of applying restorative approaches within its social and legal institutions,[7] and had developed a national and international reputation for expertise in restorative approaches. However, the reception for this aspect of our mandate ranged from positive to apprehensive among those engaged with our work. According to the Orders in Council and in keeping with the various Nova Scotian models, we designed our process to emulate restorative principles on a structural level, seeking to be inclusive, transparent, and collaborative. People often conflated restorative approaches with being trauma-informed, but restorative principles and a trauma-informed approach, while complementary, are not one in the same. The misconceptions around restorative concepts, added to a considerable amount of misunderstanding about the inquisitorial process, meant that this part of our mandate was a source of ongoing confusion for some. The other sections of this volume enumerate the many ways in which restorative principles shaped and guided our commitment to engaging with Participants in an ongoing and participatory way, to helping the public get good information in accessible ways, and so on. Although we found these concepts helpful and important to our work, taking a restorative approach was a source of continual difficulty because of the lack of understanding and experience with such principles by some of those engaging with this work, including Participants, members of the public, and commentators. There is much to consider for future inquiries in how to interpret and apply this type of requirement in a mandate.

Putting Principles into Practice

A restorative approach is human-centred, focusing first on the people involved and their connections. It is based on building relationships among them as a foundation for the work at hand. In our statement of vision and values (see Chapter 3), we captured this idea in our commitment to conduct our work with humanity and compassion for all involved in our process.

That pledge did not compromise procedural fairness, nor did it mean avoiding disagreements or not sharing emotional or difficult information. Rather, it meant taking active steps to avoid harm wherever possible; attending to the connections with those most affected and with communities, and ensuring those connections were approached with care and concern to ensure their dignity and well-being were respected. Throughout the Commission process, this approach meant identifying moments in which to include people and seek information and feedback. Fostering a restorative approach was an indispensable yet largely misunderstood method, underappreciated by critics as a legitimate part of our mandate.

Restorative principles require a non-adversarial, inclusive, and collaborative approach. They oblige us to focus on facts and issues in context rather than in isolation, and on accountability and responsibility rather than liability or blame. These principles underscore that in seeking answers, we can develop clear understandings, acknowledge harms done, and develop practical reforms.

Although these qualities are all consistent with the role of a public inquiry, we found that they encouraged us to look beyond traditional public hearings as the central feature of our work. They helped us concentrate on understanding the causes, context, and circumstances of the mass casualty and kept us focused on identifying the lessons to be learned and formulating our forward-looking recommendations. Having all had lengthy experience with the ways in which the adversarial process is an often unsatisfactory means of getting answers to complex questions, we sought to use a variety of methods to gather evidence and assemble an evidentiary foundation. The idea that a formal and legalistic hearing is the only way to do this work has been debunked by years of calls for improved access to justice because the traditional adversarial legal system can often do more harm than good.[8] An adversarial approach oversimplifies issues and positions, is often

harmful to those affected, and excludes many who have important and valuable contributions to offer toward solutions but who do not fall on one side or the other of an issue. Indeed this is one of the risks of inquiries generally: they are set up to act in the public interest and to be able to support and welcome multiple perspectives and participants, and yet the heavy involvement of lawyers, including commission counsel, can easily create a situation where people fall into unhelpful roles borrowed from adversarial processes where one side is prosecuting and others defending.

The Orders in Council directed us to do no further harm, to be trauma-informed, and to be attentive to the needs of those most directly affected and the impact of the mass casualty on them. We interpreted this group to mean *all* of those most directly affected, including families of those whose lives were taken, those injured (including Portapique resident Andrew MacDonald and the perpetrator's common law spouse, Lisa Banfield), and the first responders involved in the mass casualty, with one colleague, Cst. Heidi Stevenson, killed, and another, Cst. Chad Morrison, injured. In addition to those directly harmed, there are many who were and continue to be affected and whose lives will never be the same because of what happened. Ensuring that our work is trauma-informed did not mean the Commission was a mental health service provider or that we were expected to play a healing role. It did not limit our ability to thoroughly and independently investigate the mass casualty.[9] In short, trauma awareness provided us with an opportunity to make adjustments to our processes that improved our ability to carry out our mandate in a way that was mindful of the potential harms to a wide array of people. When we designed our process, restorative principles required us to first ask why we would do something a certain way; then, once we had identified our purpose, we would look at how we might do it and what we would do to accomplish the purpose.

We aimed to build relationships of mutual respect with Participants and their counsel / representatives. Through our regular engagements with Participants and their counsel / representatives, we were able to learn about specific issues that were of concern to Participants and share that information internally with the Commission's investigative and research and policy teams. Commission staff were available to quickly answer questions or get direction on issues as they arose. We dedicated a community liaison team, several senior Commission counsel, a member of the research and policy team, as well as support staff, to specifically liaising with Participants and their counsel, in order to ensure that they were supported daily in the Inquiry process. The approach to developing Foundational Documents, described

in Chapter 3, underscored the importance of sharing information and progress on finding answers in real time, as well as enabling Participants to contribute to the work in meaningful ways from well before the start of public proceedings.

When conducting interviews, Commission staff were flexible about when and where they met people. Individuals interviewed were invited to bring a support person, including at times a union representative, to the interview if they wished. For family members of the deceased and for survivors, the Commission interviewed only those individuals who wanted to meet with us, and we received written statements and affidavits as well. Rather than transcribe interviews with family members of the deceased, which often covered very personal and sensitive material not all of which was required to be part of the Commission's public record, Commission counsel prepared summaries. Family Participant counsel were able to review the summaries and make changes based on what information their clients wished to have made public.

We had heard from those most affected how difficult it was to hear information about the mass casualty from media. As a result, sharing information with those most affected before it was shared with the public was very important. Sharing information as the Commission was receiving it was facilitated with confidentiality undertakings, which ensured that all Participants had the opportunity to review with their counsel documents that may have especially affected them before it was entered as an exhibit and therefore made public. The Commission also shared its decisions with Participants in advance of the media.

We stayed in regular contact with Participants, community members, and stakeholders. We reached out to connected organizations and institutions to determine how they might engage with us, and what information and supports their constituents needed to do so. We also sought their advice about how best to engage with their communities. Our weekly updates were one way we stayed in touch. (A sample update is included in Annex A.) As we outline in the "Public Engagement and Communications" section in Chapter 3, the Commission provided updates regularly from the very beginning, even when updates were smaller in nature and not always "newsworthy." Participants (including families) received the update first, followed by other stakeholders, media, and posting to the website. This sequence was based on input received by families and others affected by the mass casualty. If consistent questions were posed, we would update the FAQs on the website and add the information to our stakeholder updates. We aimed to support the people and agencies who were working to help others throughout the

process. For example, Commission staff met with community-based organizations that provide support services in the affected communities, ensuring they had the necessary information about the Inquiry process and knew what to expect so they could prepare to assist others. We tried always to ask, "What else is helpful for us to consider as we do our work, and what do you need to do your job?"

Understanding that counsel for those family members, as well as counsel representing first responders, had difficulty sharing information collected by the Commission with the people they represented and receiving instructions from them, we were flexible and often granted extensions to deadlines or rescheduled planned meetings.

The Commission received some very sensitive and graphic information, including the reports of the medical examiner and photographs from crime scenes. Because of its nature, some of this material was not distributed to all Participants and was not entered into the public record of the Commission. However, recognizing that some Participants might want to view material that related to their loved ones, the Commission developed a process through which Participants could request to view it with their counsel, based on these criteria: how viewing the unredacted evidence would materially assist their meaningful participation in the work of the Commission; the extent to which access may affect the security, dignity, and privacy interests of people not represented by the requesting counsel; and whether there are appropriate mental health supports in place to ensure that the Participant has considered the risks of access and whether the Participant would have appropriate support after having had access, if granted. We discuss this process further in the "Protocols for Graphic and/or Potentially Harmful Materials" section of Chapter 4. The Commission offered access to mental health supports, where needed and wanted, for those engaged in our process. This support included having members of our mental health team on-site and available to provide pathways to wellness supports for Participants who attended the Commission's offices to view graphic and sensitive material.

When we were designing the public proceedings, we were mindful of logistics including the layout of the room, the level of formality, and the overall atmosphere of the space. In keeping with our restorative approach, we sought to create a space for the proceedings that would disrupt the traditional hierarchy, imbalance of power, and control in traditional civil and criminal court settings. We hoped to encourage collaboration, civility, and compassion in all aspects of our work. We discussed at length with our logistics staff how to set up the room for the various

sessions to come. We wanted to be on a low platform, not on a stage or at a podium, and we did not want a traditional "witness box." We decided against the traditional direction of "all rise" when we Commissioners entered the proceedings room.

During our logistics discussion, we talked about seating, tissues and glasses of water, breakout spaces, sound systems, and screens, all in trying to make the space comfortable for Participants, the public, witnesses, and presenters. At one point, it was brought to our attention that some of the first responder witnesses may appear in uniform or bring their police equipment as props to demonstrate their work. Our thoughts quickly turned to the fact that the perpetrator was wearing a police uniform in the April 18 and 19, 2020, mass casualty. We realized that officers as witnesses showing up in uniform could be traumatizing or intimidating for some, if not many, who were directly affected. Although we recognized that the wearing and carrying of issued police kit was important to some police officers, on weighing the potential negative impact we made a decision to request that no one (witnesses, Participants, observers, or hired security) would appear in police uniform. We directed that this decision be communicated to witnesses in advance of their appearances. (This direction was not communicated in one instance, and in a virtual appearance an RCMP officer was in uniform.)

The Commission's intentional absence of uniforms went largely overlooked until the testimony of RCMP Commissioner Brenda Lucki in August 2022. Despite appearing toward the end of proceedings, and after many other RCMP and municipal police officers and leaders alike, Commr. Lucki's attire generated significant criticism on social media. This commentary included critique about her clothing, and mutated into questions about her professional competence as leader. It is noteworthy that several currently serving male police officers, including chiefs of police, complied with the Commission's direction and testified in civilian clothing, seemingly without notice.

> Regardless of whether an inquiry is mandated to take a restorative approach, care should be taken with every decision to consider the human beings in the systems under scrutiny.

The Importance of Language

A major aspect of the restorative approach we employed was the Commission's close attention to language and terminology. One of our guiding principles was to be respectful and to recognize that "every word matters." The Commission prepared an internal lexicon of key terms that we considered through a trauma-informed lens and aligned with our mandate and our integrated team approach. In our view, using specific terminology helped to ensure clarity and consistency across the many team members working on the Inquiry. We updated our lexicon several times to integrate feedback we received on language from experts and from those most affected, as well as to reflect specific decisions we made around phrasing. Our evolving use of language is an example of how we continued to learn and adapt as we carried out our mandate.

We share a few examples to illustrate the importance of language. In the Orders in Council establishing the Commission, the events of April 18 and 19, 2020, are referred to as a "mass shooting." We considered it important to recognize that many types of harms resulted from this occurrence, in addition to gun-related deaths and injuries. The Commission chose to use the broader term "mass casualty" to encompass these other harms.

Another example is our decision not to use the word "victim," even though the Orders in Council refer to "innocent victims" and "victims and their families." Our decision was consistent with restorative principles and in accord with feedback we received during our early consultations with family members and experts. Wherever possible, we used the phrase "those most affected" (also derived from the Orders in Council) as an inclusive term to refer to the affected individuals, families, first responders, service providers, and communities.

We made a third early decision not to mention the perpetrator by name or to use the terms "gunman," "shooter," or "lone wolf" in referring to him. We took this step to help minimize the perpetrator's notoriety and associated social status.

The Commission's website included a "key terms" section for the duration of our mandate. On that web page, we defined terms that the Commission used frequently in our work, but which were not commonly used in daily conversations. We created this web page to ensure that the Commission's process was accessible and could be easily understood by members of the public who wished to follow our progress.

> The importance of choosing and using words carefully and consistently in all aspects of an inquiry's work cannot be overstated.

Differentially Affected Groups

Our mandate required us "to give particular consideration to any persons or groups who might have been differentially impacted by the tragedy." Seeking out and valuing knowledge and input from individuals and groups with different lived experiences was also a component of our restorative approach.

Early in the design of the Inquiry, our research and policy team developed a framework to assist us, in all stages of our work, in paying attention to groups and individuals identified as differentially impacted by the mass casualty and, more generally, by the dynamics of policing, rural living, and violence at the core of the Inquiry. As a result, facts about the causes, context, and circumstances of the mass casualty that otherwise would have been largely overlooked came to our attention; for example, the impact of the mass casualty on members of the Millbrook First Nation and the fact that the perpetrator had targeted poor and racialized women for violence over many years.

Given the many past reports which indicate that actions related to aspects of our mandate, such as policing and gender-based violence, can have disproportionate effects on Black, Indigenous, Two-Spirit, lesbian, gay, bisexual, trans, queer and intersex people (2SLGBTQI+) and other historically disadvantaged groups, we made efforts to include those perspectives in our process. For example, we sought to include those voices at our roundtables and embarked on outreach to create space for some who have been so disenfranchised that they would not otherwise try to participate in an inquiry process. For example, later in this volume (Chapter 4) we discuss our unique engagement with two Participants; namely the Avalon Sexual Assault Centre and the Elizabeth Fry Society of Mainland Nova Scotia. These two groups have considerable experience working with racialized and criminalized women and gender-diverse persons and offered to use their expertise in facilitating the Commission's consultation with these communities. Avalon helped us greatly by having its community navigator facilitate consultations with African Nova Scotian women. This process produced the report by the Avalon Sexual

Assault Centre and Women's Legal Education and Action Fund (LEAF), participating as a coalition with Women's Wellness Within, which showed that the perpetrator had targeted African Nova Scotian women for exploitation and violence. The report is reproduced in full in Annex B. The Elizabeth Fry Society was equally helpful by facilitating a consultation with women imprisoned at the Nova Institute for Women in Truro, Nova Scotia. Both consultations proved to be very enlightening and would never had occurred under a more traditional process.

The requirement in our mandate to particularly consider differentially impacted groups prompted us to seek input in framing recommendations to avoid inadvertently deepening structural inequalities. Several roundtable members told us those structural inequalities, such as poverty and racism, produced violence in the first place. We were advised to make recommendations that balance making communities safer with recognizing the rights of people in communities that may be disproportionately affected by the course that is taken to do so, and we have attempted to take this advice into account in framing our recommendations.

> Our consideration of impacts on differentially affected groups, and the flexibility of our process, allowed us to gather evidence that would not have been obtained under a more rigid legal process.

CHAPTER 3

Designing the Inquiry

CHAPTER 3 Designing the Inquiry

When it came to designing the Commission, our starting point was the mandate given to us by the Governments of Canada and Nova Scotia. With this guiding framework, we discussed options and consulted with other experts about the most efficient and effective way to fulfill our task. At the same time, we began to build the Commission teams and attended to other practical details involved in establishing our infrastructure, including the setting up of our offices in Truro and Halifax. As a team, we engaged in planning processes to develop our guiding vision and approach to our complex mandate.

Consultation

Upon our appointment, we were eager to get the Inquiry underway. We realized that pressure had built among Nova Scotians during the months when the federal and provincial governments were deciding to hold a public inquiry, crafting the Orders in Council, and appointing us as Commissioners, and there was a sense of urgency from the public for information about what had happened, how, and why. Like all commissioners, however, we had to start by developing a budget, building a team, finding premises for our offices, and creating a plan for our work. Initially, we began our work in a borrowed boardroom in Halifax, at that time a city in lockdown.

We had not worked together before, but we quickly connected to begin our work and discuss how to fulfill our mandate through our Inquiry process. From the beginning, we endeavoured to reach decisions by consensus, and we were successful in doing so over the next two years. We immediately agreed on our first preliminary step: consultation. We spoke with many individuals, most of whom had

previously served as commissioners or as senior members at other Canadian public inquiries, and asked for their advice on a broad range of issues. They included (in alphabetical order) the Honourable Louise Arbour, Ronda Bessner, Christa Big Canoe, Jennifer Cox, KC, Susheel Gupta, Patricia Jackson, Professor Jennifer Llewellyn, the Honourable Dennis O'Connor, and Professor Kent Roach. They and others were generous with their time and gave us invaluable advice, helping us to avoid pitfalls and providing a solid grounding on which to make our formative decisions. Several of them continued to assist us as we carried out our mandate.

As a priority, as soon as public health guidelines for COVID-19 allowed in March 2021, we began to meet with some of the people who were injured and with many family members of those whose lives were taken by the perpetrator. The invitations were to people who were automatically given the opportunity to participate in the Inquiry by virtue of the Orders in Council. These meetings were arranged with the assistance of our public engagement, community liaison, and mental health teams working with representatives of provincial Victim Services, part of a department that provides information, support, and assistance to victims who are interacting with Nova Scotia's criminal justice system. Not everyone accepted our invitation, and some individuals and family members who did not meet with us initially decided to meet with us later, in September and October 2021. In all these meetings, we listened to the experiences of those most affected. We also explained our Commission's work and approach and shared how, as some family members became Participants in the Inquiry, they would meet again with Commission counsel and other staff members. We are grateful to those who agreed to meet with us; the views they expressed galvanized our work. All our encounters with them have left an indelible impression on us.

We advise early consultation with past inquiry commissioners, counsel, and advisors at the outset of a mandate. Once basic infrastructure is in place, it is essential to meet with those most affected as early as possible.

In planning the initial meeting with families and individuals most directly affected, there are a number of details to consider. Commissioners need to be mindful that each person and family will have their own unique needs and expectations. Planning is important and should include:

- initial outreach and communications plan;
- charting of family relationships;
- establishing parameters of meetings;
- legal guidance;
- scheduling;
- travel arrangements and financial support;
- meeting locations;
- room arrangements;
- food and beverages for attendees;
- technical support (virtual attendees); and
- mental health supports.

Offices

One of our early practical decisions was to create two offices: one in Truro and the other in Halifax. We made this decision because we wanted the Commission to be accessible to members of the communities most affected by the mass casualty. Establishing a Truro office was one step we took toward this end. That office, which we set up in January 2021, was an anchor for our community liaison and investigation efforts as well as for meetings with families and witness interviews. Given the ongoing COVID-19 pandemic, at times people could not travel between regions because of public health orders, so it was useful to have a presence in both Colchester County and the Halifax Regional Municipality.

Establishing a presence in affected communities is convenient but also important for building local connections, engagement, and trust.

The Commission's Vision and Values

Public inquiries are independent bodies that operate at arm's length from governments. This practice means that although the Commission's mandate was established by governments and we were funded by them, we controlled how the Commission carried out our work. One of our first steps as Commissioners was to craft a statement of vision and values to guide our decisions, practices, and processes as we worked to fulfill the Commission's mandate.

Vision

Our vision was to provide clarity around the causes, context, and circumstances that led to the April 2020 mass casualty in Nova Scotia and to make meaningful recommendations to help keep communities safer in the future.

Values

We chose the values of independence, respect, and transparency to guide our work, and we sought to uphold those values in the following ways:

Independence: We ensured that the Commission was independent of any governments, institutions, or other associations of individuals or groups.

Respect: To create a thorough, evidence-based record, we knew that difficult questions would need to be asked and uncomfortable facts would need to be considered. We sought to perform our duties with compassion and with an unwavering commitment to a full, transparent, and independent Inquiry.

Transparency: We strove to make the Commission's process inclusive, accessible, transparent, and conducted with humanity. The Commission would listen, learn, and investigate. We would share what had been brought to light in a Final Report, with sustainable recommendations and a thorough, evidence-based record.

We designed our statement of vision and values based on our Orders in Council. This approach put restorative principles to work in the context of our Inquiry. Our principles acted as guideposts against which we measured every choice we made, both as Commissioners and as members of the Commission team. Principles translated into practice through, for example, our rules and decisions on participation

and funding recommendations (Appendix B); our Rules of Practice and Procedure (Appendix C); the design and content of our website; our statements to the public; the ways we communicated with Participants, their counsel, and members of the public; our decisions about evidence, exhibited documents, and witnesses; and this Final Report. These principles continued to guide us until our Inquiry was complete and we submitted this Final Report to the federal and Nova Scotia governments.

> An inquiry's independence is its bedrock. Respect and transparency must permeate its work.

The Commission Staff

Throughout the fall and winter of 2020–21, we assembled our staff by selecting each member on the basis of their individual knowledge, skills, and expertise.[1] The three of us set up virtual meetings, in large part due to COVID-19, first to gather recommendations and then with candidates. Our focus was to hire people with the necessary experience but also with a dedication to public service. Further, we sought staff from or with a connection to Nova Scotia and who were neither in a personal nor a professional conflict to take on the work. We remain proud of the fact that we secured so many qualified women to fill important positions. They represent the next generation of excellent women leaders in different disciplines who can mentor younger members of their professions. However, we had less success in hiring staff from historically disadvantaged groups, likely in no small part because we are three white privileged Commissioners in professions that are predominantly white – so our networks reflect that fact. We also want to acknowledge that the Commission's 2SLGBTQI+, racialized, and Indigenous staff members carried the additional burden of representing unrepresented or underrepresented constituencies in our work.

Among the most important appointments we made were the directors for the various Commission teams, who brought extensive, relevant, and valuable experience and perspectives to our work as well as a demonstrated commitment to public

service. The teams – legal, investigations, research and policy, community liaison, public engagement and communications, and mental health support – were assisted by the secretariat, which provided operations support across all teams as required for the daily functioning of the Inquiry. In addition to these categories of "teams," we created a thematic "pod" structure allowing our Commission teams to operate as collaborative cross-disciplinary groups to address the specific issues set out in the mandate. We review the roles of each team and pod in greater detail below.

Two features are particularly important to the way we Commissioners structured our working relationships with the broader Commission staff. First, although the Commission team was integrally involved and provided input along the way, with respect to making choices about how the Commission's work was carried out and in determining the core Inquiry processes, the final decisions were always ours.

Second, collaboration was key to our workplace culture, especially since we were a team of three Commissioners. We recognized that we each brought unique perspectives, experience, and knowledge to our task, and we shared the work among us, both functionally and by subject matter. We encouraged inclusive and integrated ways of working within teams, across teams, and with outside parties. For example, to avoid having to re-interview people, we compiled all relevant questions by arranging witness interviews with input from the investigators, Commission counsel, and research and policy team members. Working this way was not only more efficient but also a way for the Commission to gather the best possible information.

Hiring Commission Resources

Our first hire was Sarah Young. Ms. Young's role as our chief engagement officer is described in the "Public Engagement and Communications" section below, but she was retained by us the day we were appointed by Orders in Council to help draft a statement (included in Annex A) so that the initial framing of the Inquiry would not be solely the purview of government, from whom we wanted to establish our independence as quickly as possible. We also retained her to answer media calls and to help us in quickly establishing the name of the Commission, a logo, and a website. We were extremely fortunate that our first call was to a person who understood the province, including having grown up in rural Nova Scotia, with a depth of experience. The former managing partner at NATIONAL Public Relations, Atlantic Canada, Ms. Young brought more than 25 years of experience providing

communications leadership and counsel for private and public organizations across Canada. Ms. Young's leadership was essential in designing, implementing, and overseeing the complex array of communications and public engagements for the Inquiry. Ms. Young immediately understood the gravity of our task and the nuances of analysis that would be required to undertake it. She and her team were essential in laying the groundwork for our outreach to those most affected, other stakeholders, the media, and the public.

Our next step was to hire Christine Hanson, who joined us as our executive director and chief administrative officer. She had previously held a variety of legal and diplomatic roles with Global Affairs Canada, and came to us from her role as the director and chief executive officer of the Nova Scotia Human Rights Commission, which is also an independent body. Her tasks included managing the Commission's budget and holding overall responsibility for our staff. Ms. Hanson also led our reporting relationships with the Governments of Canada and Nova Scotia, including recording and reporting on our financial expenditures as well as leading the process of securing an extension for the submission of our Final Report. With Ms. Hanson's assistance, we secured our offices in Truro and Halifax, developed internal policies, and built our Commission teams. Her ability to work with the Privy Council Office in a constructive manner was a tremendous asset in helping the Commission navigate its work smoothly and independently. A solid understanding of government procurement, funding, and other guidelines, along with a diplomatic approach, proved an essential skillset. In addition, Ms. Hanson's skill in human resources management ensured a very high retention rate of the staff throughout the life of the Commission.

We consulted advisors, hired directors, and brought on other staff over the ensuing months. Canada has a rich history of public inquiries, and we wanted to learn from best practices and build our own. We engaged three senior advisors, all with significant inquiry experience, to assist us in this regard.

Ronda Bessner acted as our senior legal advisor, providing advice on matters relating to our role as commissioners throughout our mandate. A law professor in the areas of public inquiries, evidence, criminal law, and youth justice, Ms. Bessner is the co-author of a leading textbook on public inquiries[2] in Canada and has served in senior roles in seven previous inquiries, including the Walkerton Inquiry, the Ipperwash Inquiry, and the Royal Commission on the Blood System in Canada. She has also made presentations on the subject of public inquiries at legal conferences

and to commissioners and commission counsel of various inquiries. Ms. Bessner is also an adjudicator on the Ontario Consent and Capacity Board.

Dr. Melina Buckley, who served as our senior legal analyst, is a retired lawyer and legal policy consultant having worked in the areas of constitutional law, human rights legislation, access to justice, and dispute resolution. Dr. Buckley's extensive experience in justice system and legal reform includes serving as project director to the Honourable Bertha Wilson Task Force on Gender Equality in the Legal Profession (1991–93), as policy counsel to the Missing Women Commission of Inquiry, and as chair of the Canadian Bar Association's National Access to Justice Committee and National Legal Aid Test Case Advisory Committee. Dr. Buckley played a lead role in developing our Interim and Final Reports.

Jennifer Llewellyn, professor of law and chair in restorative justice and director of the Restorative Research, Innovation and Education Lab (RRIELab Restorative Lab) at Dalhousie University, acted as an advisor throughout the mandate. A renowned international subject matter expert in the area of restorative approaches, Professor Llewellyn facilitated the design process for the first-ever restorative public inquiry (into the Nova Scotia Home for Colored Children) and served as one of its commissioners. She has advised and supported many governments, projects, and programs, including truth and reconciliation commissions in Canada and South Africa, the governments of Jamaica and New Zealand, and the United Nations.

We benefited from the sage advice and contributions of these three advisors on a range of matters throughout our mandate.

> To facilitate a workable balance between maintaining independence and functionality, public inquiries require senior and administrative level staff who are experienced working with federal / provincial government financial controls and procurement rules. Strong government relations and human resources experience will be extremely helpful. Ideally, the staff will be familiar with the mechanics of an inquiry and related government policies.
>
> The importance of experienced public engagement and communications personnel cannot be overstated.
>
> Obtaining advice from people with previous inquiry experience is critical to all aspects of an inquiry's work.

Secretariat

Led by the executive director and chief administrative officer, the secretariat supported all administrative aspects of the Commission's operations and the proceedings. In the role of Operations Director, Ted Aubut provided constant support and assistance to us Commissioners. Secretariat staff established our offices in Truro and Halifax, developed workplace policies, recruited highly qualified individuals, and supported remote work and travel. They managed records, developed and maintained vendor relationships, and provided strategic and project-planning support across our teams. For the proceedings, this team secured venues and managed day-to-day logistics, including registration, security, scheduling, simultaneous translation, and the many technical aspects of running a live webcast. With their vendor partners, they performed the back-of-house functions necessary for more than 70 days of public proceedings to run smoothly and efficiently, all in the changing landscape of COVID-19.

Commission Counsel

Commission counsel are the lawyers who work for a public inquiry. They act on behalf of the public interest following the commissioners' instructions, and they provide support and advice on a wide range of issues. Commission counsel work collaboratively within the commission to analyze source materials; identify key themes and issues; interview witnesses; draft and present documents to build the factual foundation of what happened, how it happened, and why it happened; and question witnesses during proceedings to elicit oral evidence. As further described below, Commission counsel chaired the working meetings on the Foundational Documents, regular meetings with Participants to update them on the process and respond to issues of concern, and caucus meetings with Participant counsel that were held during witness testimony at public proceedings. Another critical function of Commission counsel is to maintain regular communication with Participants and their counsel, allowing many questions and issues to be addressed informally without the need for a formal ruling. Commission counsel in this Inquiry provided advice about requests, correspondence, and applications we received from Participants concerning such matters as disclosure, proceedings, and witnesses. As noted, we played an active role as inquirers, directing Commission counsel throughout our mandate so they could support and assist us in that function.

The role of Commission counsel, like that of the Commissioners and the rest of the Commission team, is to be objective and impartial. Counsel ensure that all matters concerning the public interest are brought to the attention of the Commissioners. Unlike in adversarial proceedings, a Commission's legal team does not act for particular interests or advocate for a client's specific point of view. Commission counsel are not criminal prosecutors, nor is their role the same as lawyers who represent plaintiffs or defendants in civil proceedings. Commission counsel assist the commissioners in ensuring that all material issues, relevant evidence, and significant theories are brought forward.

The Honourable Thomas Cromwell, a former justice of the Nova Scotia Court of Appeal and the Supreme Court of Canada, agreed to serve as the director of Commission counsel and acted as the Commission's main liaison with counsel for the Governments of Canada and Nova Scotia. He directed a team of six senior Commission counsel – Roger Burrill, Jennifer Cox, KC, Emily Hill, Gillian Hnatiw, Jamie Van Wart, and Rachel Young – who led the majority of evidence at the proceedings. Ms. Young also oversaw the Commission's process of document production (incoming) and disclosure (outgoing to Participants and then the public). Senior Commission counsel, in turn, were supported by a superb team of lawyers, paralegals, legal assistants, and a registrar.

The Commission benefited from the counsel team's experience with inquests and previous inquiries, and from their combined expertise in areas such as criminal, civil, and administrative law; intimate partner violence; gender-based violence; and financial crime. Among many other responsibilities, Commission counsel reviewed and analyzed document production, prepared and presented the Foundational Documents, participated in witness interviews, liaised with Participants and their counsel, and conducted legal research and analysis of a range of issues. Commission counsel provided advice to our communications team about responses to queries from media. They also provided input to help us as Commissioners develop the processes that we would follow to execute our vision; for example, the systems we would use to receive and incorporate feedback on Foundational Documents and the protocol we would use to identify witnesses and coordinate the questions for their interviews among our internal teams.

In March and April 2021, we issued instructions for Commission counsel – an internal document to guide the Commission counsel team as they carried out their responsibilities (see Annex A). In our instructions, we emphasized that, as an extension of the Commissioners, the role of Commission counsel is to represent the public

interest. We reiterated that we, as Commissioners, had the ultimate responsibility for making decisions, determining the factual record, and developing the Commission's final recommendations. To reach those determinations and develop those recommendations, however, we needed input into the Commission's process. We instructed Commission counsel to consult us on all major decisions and to gather and analyze evidence in a fair and impartial manner that served the public interest.

Investigations

The investigations team assisted the Commission in determining the facts of what happened, as well as how and why it happened. The team's investigative efforts and analysis set the foundation for discussions and consultations about the broader context in which the mass casualty occurred, and what could be done going forward to enhance community safety. The investigations team worked closely with Commission counsel and the research and policy team, focusing on areas of expertise, including:

- operational police tactics, responses, decision-making, and supervision;
- communication with the RCMP, with other police forces and agencies, and with the public;
- training policies and practices related to gender-based and intimate partner violence and active shooter incidents; and
- policy and practices in the management of police equipment and vehicles.

Although the initial and primary focus of the investigations team was to assist in building the factual foundation in Phase 1, team members also assisted us as we examined the broader issues within our mandate.

Barbara McLean served as our director of investigations. A senior police leader with a long and distinguished career with the Toronto Police Service, she held the rank of deputy chief. Ms. McLean grew up in Antigonish, Nova Scotia, where she graduated from St. Francis Xavier University. She was on secondment with the Commission and assembled a team of 10 investigators, including an intelligence analyst. The team members she recruited were subject matter experts in specialized police operations, including incident management and emergency response; gender-based violence; complex investigations, including homicide, financial

crimes, organized crime, source management, and professional standards; and police training. Many had been supervisors in their various policing roles; our analyst was a former member of the Canadian military, experienced in data analytics and visualization. Team members were also recruited for their familiarity with Nova Scotia specifically or the Maritimes generally, and for a demonstrated public service orientation. This last quality was non-negotiable. To maintain investigative independence in conducting work on behalf of the Commission, no current or former members of the RCMP or any Nova Scotian police service members were hired for this team.

Using the major case management model and its standard for criminal investigations, Ms. McLean's team was responsible for the speed, flow, and direction of investigative efforts. Other key roles within this model included the file coordinator, lead investigators, primary investigators, and an intelligence analyst.

Throughout our mandate, the investigations team was responsible for interviewing potential witnesses, reviewing and analyzing materials received through the production process, assisting with the preparation of Foundational Documents, and pursuing answers to outstanding questions from Participants or the public and filling gaps in the factual record.

> The Commission benefited from having investigators available to all teams for the duration of the mandate, a further example of the usefulness of cross-team collaboration.

Research and Policy

Our mandate required us to understand how and why the mass casualty occurred and to make recommendations that could help protect communities in the future. Our work therefore had a strong research and policy component, which helped us to take the information gathered in the investigation and place it into a broader systemic and institutional context, ensuring that we were able to make meaningful recommendations.

Dr. Emma Cunliffe served as our research and policy director. She is a professor at the Peter A. Allard School of Law at the University of British Columbia

and a visiting professor at the Schulich School of Law at Dalhousie University. Dr. Cunliffe's research focuses on the investigation and fact-finding process in complex criminal matters, and her expertise in the field of expert evidence is recognized internationally.

The research and policy team worked closely with Commission counsel and the investigations team to ensure that our work was evidence-based and to help us look closely within Nova Scotia, across Canada, and around the world for good ideas and best practices. Many public inquiries carry out the fact-finding and policy dimensions of the mandate as separate aspects. As noted, our mandate framed these two aspects of work as integral to each other.

We recruited our research and policy team for their expertise in key aspects of our mandate, including police accountability mechanisms, gender-based and intimate partner violence, and the provision of emergency healthcare services. These team members had experience on prior commissions of inquiry and had conducted policy-oriented research in the not-for-profit sector and carried out relevant academic research. Many were also qualified lawyers, skilled in reviewing our documentary records. Several members of this team had close and continuing ties to rural Nova Scotia and brought a deep understanding of the cultural context of our work, including with regard to diversity in rural communities.

The research and policy team helped us to prepare the factual record, review the documents produced by institutional Participants, and identify and gather relevant policies and research studies. With Dr. Cunliffe's intellectual leadership, the team also assisted us in designing and implementing an extensive research and consultation program, including the environmental and international scans, as well as the scoping and coordination of 23 commissioned reports and 21 roundtables. Our roundtables in particular drew directly on the mix of research, policy, and community expertise that our research and policy team contributed to our work.

As part of our integrated model, the research and policy team also identified witnesses who were important to the systemic aspects of our work and led interviews of them. The team helped us to build our evidentiary record with respect to differentially impacted communities, address questions of funding and implementation of past policy initiatives, and examine systemic barriers to improving institutional processes. Members of the research and policy team also regularly joined Commission counsel and investigations colleagues in interviews with witnesses who also had direct factual evidence to share, ensuring that questions about policy matters were explored.

In addition, the research and policy team initiated our public consultation on policy matters and the conversations we held with those communities who were most directly affected by the mass casualty. These and other aspects of their work are discussed in Chapter 4, where we outline our Phase 2 and Phase 3 proceedings. The team was also instrumental in assisting us in parsing our mandate, structuring our conceptual approach, and ensuring we attended to all aspects of the questions before us. Dr. Cunliffe played an integral role in the report writing phase of our work.

> Integrating the factual and policy aspects of an inquiry's mandate produces a richness and depth to the record that tangibly serves the public interest.

Public Engagement and Communications

Public engagement and communications played a key role in all aspects of the Commission's work, ensuring that members of the public knew what to expect and how to take part in our work.

As we describe in more detail below, the Commission undertook a range of initiatives to communicate with the public, to liaise with the most affected individuals and communities, and to encourage broad public engagement in our work. In carrying out our role as Commissioners, we knew we had to establish and maintain trust in, and an understanding of, the Commission's work. We did not take this trust or understanding for granted; in fact, we and our team knew we had to work with great care to earn it. We knew that we would be able to fulfill our mandate only with the co-operation of the community, and that our findings and recommendations would be most effective if they were accepted by society and championed through community and institutional leadership. From our first day on the job, our communications and engagement work was an important vehicle for maintaining transparency and accountability. That commitment continued until we completed our work.

As noted above, our chief engagement officer was Sarah Young. She was essential in designing, implementing, and overseeing the complex array of communications and public engagements for the Inquiry. Ms. Young assembled a team of experienced communications and outreach professionals from the community, public,

and private sectors. The team brought perspectives from rural Nova Scotia, across Canada, and globally. Together, they ensured that:

- interested and diverse members of the most affected communities, and communities throughout Nova Scotia and beyond, had easy access to information and were aware of and felt encouraged to engage with the Commission;
- media across the country and beyond were informed of and engaged in the Commission's work, and were able to provide input and receive regular updates;
- key stakeholder organizations were consulted to ensure an inclusive lens informed our work; and
- all members of the Commission were informed by input from the community.

Significant media coverage led up to and continued through our proceedings. We relied on the expertise of the public engagement and communications team to ensure that all media outlets, large and small, received timely and accurate information. As part of this commitment, we appointed Senior Commission Counsel Emily Hill and Rachel Young, Investigations Director Barbara McLean, and Research and Policy Director Emma Cunliffe as spokespeople, providing media briefings and responding to media inquiries (further discussed below, in the section on the media). They were well placed for this role, given their good understanding of the legal, policy, and investigative work of the Commission, which were the areas of significant interest to the public and media.

In addition to media relations, the team regularly engaged with local, provincial, and national stakeholders. These relationships proved invaluable to the Commission. Benefiting from the team's insights and expertise, we were able to proactively identify and resolve emerging issues. Just as importantly, our outreach allowed us to share what lay ahead for the Inquiry and thereby prepare, together, for the difficult information that would be made public. For example, some service providers increased staffing or briefed their staff at key points of the Inquiry in anticipation of higher demand for service.

For our work to be as accessible as possible, the public engagement and communications team designed and maintained a comprehensive bilingual website that, among other things, included a document library of more than 6,000 source materials. The team worked closely with mental health professionals on the design, accessibility, and content of the website.

Community Liaison

Maureen Wheller, our community liaison director, worked closely with the public engagement and communications team to ensure that we were connected to the communities most affected by the mass casualty. Ms. Wheller has worked extensively in the field of mental health and addictions communications, with a focus on building relationships among community-based organizations, public and private sector partners, individuals, families, and healthcare providers to promote understanding through dialogue.

Based out of the Commission's Truro office, Ms. Wheller was a reliable and direct contact for many family and community members. She played an important role answering day-to-day questions for those following the Commission and in managing opportunities (such as the small group sessions) to engage family members directly in our process. This work complemented the Commission's engagement with Participant counsel.

> Staff can be a human connection to the inquiry. A local presence in affected communities is essential.

Mental Health

The Commission's mandate meant that we would be sharing difficult information with those most directly affected and the public over an extended period. It also meant that our team would be immersed in difficult facts and issues arising from the mass casualty as we worked to tell the story of what happened, and how and why it happened. We were also mandated to be guided by restorative principles in a way that was inclusive of a trauma-informed approach. This meant minimizing the potential for further harm and retraumatization, and enhancing people's sense of safety, control, and resilience. We sought to integrate careful consideration of health and well-being into all aspects of the Commission's work, including ensuring access to wellness supports at every step of the Inquiry.

Recognizing that, in the course of our work, mental health and wellness supports would be required both externally and internally, the Commission established a mental health team as a priority early in its mandate. The public, Participants,

witnesses, and others engaging with the Inquiry would need to be made aware of pathways to wellness supports and require navigation to referrals for counselling. Commission staff would also need access to wellness supports over the course of a limited term high-paced work environment, dealing with distressing materials, intense public scrutiny, and people experiencing trauma. Our team developed protocols and clear pathways.

Mary Pyche, an MSW registered social worker, served as our mental health director and ensured we provided pathways to wellness supports to those affected by the Commission's work. Ms. Pyche has more than 30 years of experience in the field of mental health and addictions as a therapist, university instructor, program leader, manager, and innovator. Her team, which included people with extensive backgrounds in mental health and wellness, informed the design of our work to ensure it was trauma-informed and provided wellness supports to everyone taking part in our work, including on-site support during proceedings and at all community and family meetings. She and her team members liaised regularly with service providers and the province's Victim Services, creating pathways to care.

> Depending on the subject matter of an inquiry, attention must be given early and often to the mental health and wellness of all concerned: staff, commissioners, participants, contractors, stakeholders, and the public.

Document Management

The document management team consisted of Commission counsel, investigators, the research and policy director, and record management staff, in collaboration with Cox & Palmer, to manage document production throughout the Commission's work.

Commission counsel and the investigations team led the work and spent several months working with record holders to identify documents requisite to the investigation. To gather documents, the Commission exercised subpoena powers under section 4 of the federal *Inquiries Act*, RSC 1985, c I-11, and section 4 of the provincial *Public Inquiries Act*, RSNS 1989, c 372.

The Commission contracted the services of Cox & Palmer, a law firm based in Halifax, as the document management firm owing to its experience assisting with the

document management process of other public inquiries, such as the Desmond Fatality Inquiry in Nova Scotia.[3] Cox & Palmer appointed a dedicated team to access the Commission documents. The firm's contract began in February 2021, after months of preparation to ensure that an appropriate document management framework and the required security clearances were in place. The document management process was conducted behind a security or confidentiality screen, which meant that only designated members of the firm who were part of the document management team had access to or knowledge of the work. This team worked tirelessly and used their extensive knowledge in information management to coordinate with the Commission in receiving document production on the Commission's behalf.

In June 2021, several months into its work for the Commission, Cox & Palmer hired the former premier of Nova Scotia, Stephen McNeil, to work in their Halifax office as a strategic business advisor. Mr. McNeil was premier at the time of the mass casualty. When he joined the firm, several Participants expressed concern about a possible conflict of interest that could interfere with the Commission's work. The Commission worked closely with Cox & Palmer to ensure that the confidentiality screen already in place at the firm would prevent Mr. McNeil from having access to any of the Commission's material or information about its work. The Commission shared this assurance with Participants who had expressed concerns. The Commission also explained that Mr. McNeil is not a lawyer and was not one of the designated persons at Cox & Palmer responsible for providing document management services to the Commission.

With these confidentiality safeguards in place, the designated team at Cox & Palmer continued their document management work for the Commission. In total, more than 80,000 documents were produced to the Commission. All documents requisite to our mandate were uploaded to and organized in Relativity, a document management software program. The documents were reviewed and redacted in accordance with both the Rules of Practice and Procedure and the Commission's mandate. Hundreds of documents prepared by the Commission, including Foundational Documents, investigations supplementary reports, and audios and transcripts from witness interviews, were also added to this database to share with Participants.

The document management team supported the work of the registrar in proceedings to prepare documents for presentation and exhibiting and then worked with the Commission communications team to share documents with the media and public using the Commission's website. The team received and responded to all inquiries from Participants, record holders, Commission staff, media, and the public

as they related to documents and disclosure, technical advice relating to access to disclosure, guidance on where to find specific documents, and requests to obtain further material where needed.

> Early engagement of an experienced document management team is critical to an inquiry's ability to begin and complete its work.

Outside Counsel

Since Commission counsel are independent counsel in service of the public interest, it was important to ensure that we had external legal counsel, should it prove necessary. Given the number of lawyers involved in a public inquiry and in a jurisdiction with a relatively small number of practising lawyers, it could have quickly become challenging to find a lawyer not "conflicted out" should a need for outside counsel have arisen (for example, if a question in a specialized area of law arose or if a Commission decision was subjected to judicial review). We thought it wise to retain a general service firm early on to avoid conflicts and to ensure timely access to independent legal advice as needed.

At the start of our mandate, we retained Marjorie Hickey, KC, and David Fraser as outside counsel to the Commission on an as-needed basis. Ms. Hickey, the deputy managing partner of McInnes Cooper in Nova Scotia, maintains a varied litigation and administrative law practice, with a focus on regulatory and liability issues for professionals. Mr. Fraser, a partner at that firm, practises internet, technology, and privacy law. Mr. Fraser regularly advises private and public sector clients on all aspects of technology and privacy laws, including compliance with Canadian privacy legislation such as Canada's *Personal Information Protection and Electronic Documents Act*,[4] Nova Scotia's *Freedom of Information and Protection of Privacy Act*,[5] and Canada's *Privacy Act*.[6]

> Commissioners, early in their appointment, should engage independent outside counsel familiar with inquiries on a standing retainer.

Participants

We use the term "Participant" to refer to individuals, groups, governments, agencies, and other institutions or entities that applied to become formal Participants in the Commission's process and were found to have a substantial and direct interest in the subject matter of the Commission's work, as well as those who were automatically given standing by our Orders in Council.

The Orders in Council that established the Mass Casualty Commission specified two entities and a group of individuals who automatically had "an opportunity for appropriate participation." Those were the Government of Canada, the Government of Nova Scotia, and "the victims and families of the victims." Our role was therefore to decide what other parties, again using the language in our Orders in Council, had "a substantial and direct interest in the subject matter" and would therefore provide us with assistance in carrying out our mandate. An applicant's "substantial and direct interest" in the work of the Inquiry that was beyond the general public interest is often related to one or more of four factors discussed below.

Application Process

In February 2021, we issued a Notice to Potential Participants to get a sense of the range of people and groups who might wish to participate in the Commission's work in planning the types of activities necessary to fulfill the mandate. In March 2021, the Commission issued a call for applications for participation to individuals, groups, and other entities. The notice and call, as well as the application form, are all included within Annex A. Although we had hoped to issue the call earlier in the year, for a variety of reasons (including lack of infrastructure) it took longer than anticipated to issue. We took a number of steps to publicize the application process and to make it more accessible. For example, in addition to the information found in the Rules on Participation and Funding, we posted notices in a wide range of media, prepared a Q&A about the application process, and invited interested individuals to contact our offices if they had further questions or required assistance.

Once we received applications for participation, we

- considered the applications and decided on whether to grant an opportunity for appropriate participation to each applicant;
- decided whether to recommend funding to Participants; and
- determined the parameters of each Participant's involvement in the Commission's work.

To be granted the opportunity for appropriate participation, applicants needed to explain their connection to the mass casualty and/or their experience and knowledge in areas that relate to the Commission's mandate. This information demonstrated whether they had a substantial and direct interest in the subject matter of the Commission. In April 2021, we issued Rules on Participation and Funding to assist applicants.

In public inquiries, the decision to grant an opportunity for appropriate participation is not a simple yes or no. Parameters to the form of and limits to participation can also be set to ensure effective, efficient, and timely proceedings. For example, a commission can direct that some applicants share participation with those with whom they have a common interest by working in a coalition. As guardians of our process, we were responsible for deciding the aspects of the Commission's work in which a Participant would be invited to engage. In the context of the Commission's work, for example, some Participants were invited to engage in all public proceedings while others engaged in only one phase of work or on only one issue within our mandate.

In some cases, we also gave direction to Participants on how they could best provide their input, either in our original Participation Decision or as our processes unfolded. For example, we sought a Participant's input in writing, through participation in a meeting or proceeding, or by inviting oral submissions at various stages of our public proceedings. Directing individuals and groups to participate in relation to the specific issues in which they had a substantial and direct interest ensured that the Commission received the benefits of a Participant's contribution while promoting efficiency. These directions were necessary to allow the Commission to address its broad mandate within the rigorous timelines established by our Orders in Council.

Our Rules on Participation and Funding (Appendix B) and our Participation Decision of May 13, 2021, along with the Participation Decision Addenda (Appendix D),

are discussed in more detail below. The addenda reflect changes to the Participation Decision regarding the opportunity for appropriate participation and funding, or other changes that occurred after May 13, 2021.

Rules on Participation

The Commission's Rules on Participation and Funding (the Rules) set out the application requirements for individuals, groups, governments, agencies, and other institutions or entities that wished to apply to be formal Participants in the Commission's process. The Rules stated that participation in various aspects of the Commission's work would be granted at the discretion of the Commissioners, in accordance with the Commission's mandate. The Rules further stated that the Commissioners would make decisions about participation in the Commission's proceedings based on the completed application form and supporting documentation, including an explanation of the applicant's substantial and direct interest in the subject matter of the Commission, having specific regard to its mandate.

The Rules provided that the Commissioners may determine those aspects of the Commission's work in which a person or entity granted an opportunity for appropriate participation may engage and the form of their participation, and that the Commissioners may direct that a number of applicants share participation with those with whom they have a common interest. We use the term "coalition" to refer to groups of applicants that we directed to work together to participate in the work of the Inquiry on the basis of their common interests.

Rules on Funding

Public inquiries do not determine whether Participants will receive funding to pay their legal and other expenses arising from their participation in public proceedings. The Orders in Council provided us, as Commissioners, with the power and responsibility to *recommend* to government authorities that public funding be provided for those who "would not otherwise be able to participate." As with other public inquiries, this funding is subject to government guidelines and may not cover all the costs of participation. Further to our Rules on Participation and

Funding, we asked applicants to provide information about their need for funding so we could make informed recommendations to the government.

The Commission's Rules on Funding stated that, pursuant to the Commission's mandate, the Commissioners may make recommendations to the Clerk of the Privy Council regarding funding for a Participant where, in the view of the Commissioners, the person would not otherwise be able to participate in the Commission. Funding recommendations correlated with the Commissioners' determination of the appropriate degree of participation for each application for funding.

Applications in writing for funding were to include an indication that the applicant requested funding because of the risk of personal financial hardship which would prevent participation; or an indication that the applicant did not require funding in order to participate.

The Commissioners made recommendations for funding in accordance with our Orders in Council. All funding recommendations were approved by the Clerk of the Privy Council, resulting in the conclusion of 45 contribution agreements. Contribution agreements do not cover all expenses incurred. The vast majority of the funds approved were to cover the costs of hourly fees of Participant legal counsel with rates and activities in accordance with Treasury Board guidelines, as well as reimbursement for travel and limited disbursements. This approved funding totalled $11.3 million and was included in our Commission budget.[7] Bills for approved expenses were submitted by Participants directly to the Commission for approval and forwarded to the Privy Council Office for payment.

Treasury Board guidelines did limit the Commission's ability to fund Participants at times, and these guidelines could be more flexible for future public inquiries. As noted, Treasury Board policy prescribes the hourly rates for counsel as well as setting a daily cap on the number of hours a Participant may bill. This policy can create a hardship when a participant retains multiple counsel and document production is delayed, requiring counsel to review material overnight. Treasury Board policy also provides a cap on the total hours that counsel may bill, even if funding remains in the agreement. Participants could not bill for experts or researchers to assist them in their work, and Participants who were not legally represented received no funding. The total cap on hours, regardless of the hourly rate counsel billed, resulted in this Commission having to amend several agreements to permit access to the funds they had already received.

When the Commission prepared contribution agreements, we did not yet know the volume and complexity of evidence that we would receive and gather. We found it difficult to forecast the time necessary to allow for Participant counsel to review the evidence. As we describe in Chapter 4, we adopted the mechanism of Foundational Documents to assist Participant counsel with their review of the evidentiary record.

> The activities set out within contribution agreements should be broadly framed to allow participants and the commission to do their work efficiently while ensuring that participant counsel can effectively represent their client.

> Inquiry staff should consider assembling a standing list of lawyers with experience representing clients in commissions. Such a list would assist with referrals for people seeking to participate with representation.

Role of Participants

The role of Participants varied according to the interest of each Participant in the Commission's mandate. For example, some Participants were in a position to assist us in our Phase 1 work, by helping the Commission understand what happened on April 18 and 19, 2020. Others were more involved in Phases 2 and 3 – exploring the broader context of how and why the mass casualty happened. All had a role to play in contributing to our thinking about potential recommendations.

Participants could be involved in a wide range of ways consistent with the Commission's Rules of Practice and Procedure. We prioritized a collaborative approach with Participants. For example, we provided Participants with disclosure of documents before they were made public, and we invited Participants to provide feedback on draft materials such as our Rules of Practice and Procedure as well as our Foundational Documents. We also invited Participants to make written and oral submissions over the course of our public proceedings, and to provide the Commission with questions or areas they wished to have explored with a witness giving oral evidence at a hearing. Other Participant contributions included

engaging in our working meetings and taking part in the planning of roundtable discussions. Participants were also invited to commission their own reports or to put research before the Commission. Though Participants remained independent of the Commission, the Commission created opportunities for Participants to work with us to help build a complete and accurate public record on which we based our conclusions and recommendations.

Not everyone who had information that was helpful to the Commission was a Participant. For example, although witnesses had an important role to play in the fact-finding work of the Commission, they did not necessarily have a substantial and direct interest in the subject matter of the Inquiry. Similarly, some individuals and groups had a genuine concern about the subject matter of the Commission or had expertise in an area that the Commission was considering. Their information, views, and suggestions were of great assistance but better suited to being shared at the engagement opportunities provided by the Commission, such as the Share Your Experience survey and community conversations, discussed in Chapter 4. We valued this input and continued to hear from interested and affected parties throughout our work.

Decisions on Participation

The Commission granted 61 individuals and groups the opportunity for appropriate participation in the Inquiry, including those most affected family members of the deceased, first responders, and a number of groups and organizations, as well as the federal and Nova Scotian governments. Some of the Participants were automatically provided an opportunity to participate pursuant to the Orders in Council. One Participant withdrew, so the Commission had 60 active Participants.

We released our decision on participation on May 13, 2021, by way of a live webcast and in writing (Appendix D-1). We had planned to release our decision in a public forum but were prevented from doing so at the last minute by public health orders as a result of COVID-19. Instead, we made the webcast accessible on our website for the duration of our mandate.

This webcast was our first public proceeding, and we saw it as an opportunity to share information with the public about our work to date and to provide an introduction to our next steps. Following our initial decision on participation, we issued

five addenda in which we added new Participants, made additional recommendations for funding, addressed concerns raised by Participants about our direction that they work in coalition with one of more other entities, and approved one Participant's request to withdraw. These decisions were issued in June, September, and November 2021, and January and May 2022. The addenda clarified or added things to our original decision (Appendices D-2 through D-6).

Our Participation Decision and addenda were based on completed application forms and supporting documentation. We received applications for participation from some individuals and groups who expressed an interest in participating in all or part of the Commission's work. In their applications, they explained their connection to the mass casualty or their experience and knowledge in areas related to the Commission's mandate. We retained the discretion to hear oral submissions on issues related to participation but, because the written application process was effective and efficient, did not exercise it.

Consistent with supporting an inclusive and participatory process, we took a broad and flexible approach to our application of "substantial and direct interest." With the structural adoption of restorative principles discussed above, in making our determination, we avoided a one-size-fits-all approach and were guided by the following:

- our mandate;
- the connection of each applicant to our mandate;
- the type of interest in the mandate held by the applicant;
- whether an applicant had a "continued interest and involvement in the subject matter of the Inquiry";
- whether an applicant may be significantly affected by the Commission's recommendations;
- whether an applicant was uniquely situated to offer information that would assist the Commission with our work; and
- the requirement to balance the need for a thorough inquiry with the need to avoid duplication.[8]

In our decision, we acknowledged that

> the April 2020 mass casualty visited unthinkable pain on the families of those who were killed and their communities. It sent shock waves

> throughout the Province of Nova Scotia that reverberated throughout our entire country. The sheer magnitude of its repercussions prompts us to interpret "substantial and direct interest" broadly so that we may hear as many affected and interested voices as possible.[9]

At the same time, we had to consider that we had an extensive mandate to fulfill in a limited time. Our challenge was to promote inclusiveness while honouring our time constraints. We met this challenge by granting the opportunity for appropriate participation to a relatively large number of Participants while being creative in finding effective ways to engage them efficiently. We also created appropriate coalitions so that several Participants could speak together on issues about which they had a shared interest or expertise. Coalitions also offered the advantage of creating balance and reducing duplication where various organizations had similar areas of expertise.

As noted, by the end of our mandate we had granted the opportunity for appropriate participation to 61 individuals (those most affected and other individuals) and groups, reflecting the scope, scale, and complexity of our mandate. One Participant withdrew from this role but continued to assist the Commission, and another passed away in December 2021. A further Participant passed away in October 2022, after the close of public proceedings. Family members stepped in to represent the interests of the deceased Participants. As a result, the Commission had 60 active Participants, 45 of whom received public funding to facilitate their participation, including for legal representation.

The list of Participants and their counsel appears as Appendix E. The following section explains the role of individual and group Participants, including coalitions of Participants, in the Commission's process.

Types of Participation and Coalitions

Those Most Affected

As noted earlier, our Terms of Reference mandated that "the victims and families of the victims" would automatically have "an opportunity for appropriate

participation" if they chose to participate. On this basis, families of the deceased and other individuals most affected were Participants in the Commission's work.

In a decision dated May 13, 2021, the Commission issued its first decision, identifying the Participants in the Commission's process. A number of families of those whose lives had been taken in the mass casualty applied, while two individual members of affected families applied on their own. Patterson Law applied on behalf of a number of family members as representatives for the families of those who had their lives taken. Later in the proceedings, Scott McLeod, Sean McLeod's brother, sought separate representation, and the Commission learned of other family members who were not formally represented at the Commission but sought to participate in other ways.

In some cases, a group of members of the families of the deceased chose to be jointly represented by a single counsel. We recognized 27 families and individuals as having an automatic right of participation on the basis of being most affected by the mass casualty. Most had retained counsel by the time of their application (as noted below). All requested funding, and we accepted the assertion made in their applications that without funding, they would not otherwise be able to participate in the Commission's process. We therefore recommended funding for all of the families and individuals most affected by the mass casualty. We list these families and individuals according to the names used in their applications:

Families:

- Family of Tom Bagley
- Family of Kristen Beaton
- Family of Greg and Jamie Blair
- Family of Joy and Peter Bond
- Family of Lillian Campbell
- Family of Corrie Ellison
- Family of Gina Goulet
- Family of Frank Gulenchyn and Dawn Madsen (Gulenchyn)
- Family of Alanna Jenkins and Sean McLeod
- Family of Lisa McCully
- Family of Heather O'Brien
- Family of Aaron Tuck, Jolene Oliver, and Emily Tuck

- Family of E. Joanne Thomas and John Zahl
- Family of Joey Webber

Individuals:

- Beverly Beaton
- Tara Long
- Andrew MacDonald and Kate MacDonald
- Lisa Banfield
- Mallory Colpitts
- Darrell Currie
- Adam Fisher and Carole Fisher
- Leon Joudrey
- Greg Muise
- Bernie Murphy, later represented by Darrin Murphy
- Deb (Debra) Thibeault

Individuals who later requested and were granted separate and individual participation:[10]

- Richard Ellison
- Clinton Ellison
- Scott McLeod

These Participants were particularly engaged in Phase 1 of our public proceedings.

Guidance for Future Inquiries Regarding Participant Representation

In our process, we received applications from counsel on behalf of families. We granted these applications on the assumption that counsel who applied on behalf of a family would work with the entire family to secure instructions, which would include managing the complexities and resolving the internal disputes that inevitably arise when working with families who have experienced a profound trauma. In some cases, this assumption appears to have been correct. In other cases, we eventually learned that counsel was taking instructions only from the legal next of

kin or estate representative without necessarily informing or consulting with other family members.

We also learned that larger family groups were not always being informed about opportunities to participate in the Commission's process. As a consequence, some family members did not always know about opportunities to make their views known, and the Commission did not have the benefit of their input. The Commission should have made clear at the outset its expectation that counsel for the families would work collaboratively with entire families.

> Although commissions must respect a participant's choice of counsel, they should ensure that it is clear who is – and who is not – being represented by given counsel.

COUNSEL ACTING IN PARALLEL PROCEEDINGS

Before the Inquiry was established, a law firm retained by some of the families had conducted its own investigation and alleged (in a proposed class action filed in the Supreme Court of Nova Scotia on September 1, 2020) that the Governments of Nova Scotia and Canada, and the RCMP in particular, were negligent and therefore responsible for their clients' losses and suffering. The proposed class action claimed financial compensation, while asserting a myriad of negligence allegations against these institutions. In February of 2021, the same law firm filed a second proposed class action, this time against the perpetrator's common law spouse, Lisa Banfield, who was also a Participant in the Inquiry. The suit claimed financial compensation against Ms. Banfield, asserting that she knew or ought to have known of the perpetrator's "tortious intentions."

The fact that a law firm representing a large number of families and survivors at the Inquiry was also prosecuting a class action civil suit on behalf of these same clients involving the same matter against other Participants created certain risks: (1) the potential for the plaintiffs in the civil claims to use the Inquiry process to advance their narratives against both the RCMP and Lisa Banfield; (2) the potential effect on document production and witness interview co-operation if the defendants in the civil claims had to more carefully consider the degree to which they could participate in the Inquiry without jeopardizing their litigation position.

Choice of counsel is an important right of any person. Chosen counsel must carefully navigate the line between what is required of them as advocates in the civil litigation process and what is required of them as advocates before a commission of inquiry. They should not be torn in their approach to participating in a process that is by design meant to serve the best interests of the public; their clients being represented in parallel processes should certainly have clarity vis-à-vis their justice pathways. Further, their clients must also consider the possibility that they may be required to retain two sets of legal counsel and go over the same information twice.

Future inquiries should carefully consider applications from counsel seeking to participate in an inquisitorial process while at the same time those counsel are prosecuting a civil claim arising from the same matter.[11]

The Law Commission of Canada and the Federation of Law Societies may wish to study whether it is a conflict of interest for a lawyer to represent clients in a public inquiry when also representing them in an ongoing parallel process regarding the same matter.

Other Individuals

We received 11 applications from other individuals who sought the opportunity for appropriate participation on the basis of their connection to the community and/or subject matter expertise related to our mandate. In our initial Participation Decision, we thanked these individuals for their interest and advised them that we required more information from them to better assess their potential contribution. We invited them to provide additional details in writing about how they proposed to participate. Based on their additional submissions, we granted the opportunity for appropriate participation to Nick Cardone and Sara Jodi McDavid because they each have unique expertise relevant to the gender-based and intimate partner violence aspect of our mandate. Mr. Cardone later decided to abandon his formal opportunity to participate but nevertheless contributed to our work as an expert report writer.

Group Applicants

We received applications from a number of groups and organizations that sought an opportunity to participate in the Commission's process based on their interest in various aspects of the mandate. To ensure an expeditious review of the issues in the mandate while making the best use of government funding, we grouped some applicants into coalitions and based our funding recommendations on the formation of these coalitions. We advised the applicant groups that if the coalitions were unworkable, they could apply to revisit our decision.

We categorized the applicant groups according to their purpose, focus, and characteristics as follows:

- victim advocacy organizations;
- health-related organizations;
- firearms organizations;
- justice organizations;
- gender-based organizations; and
- police-related organizations.

The role of these applicant groups in the Commission's process and the coalitions we directed are described below. More information about each group Participant can be found in our Participation Decision.

Coalitions made different decisions about how to organize themselves for their work with the Commission. One retained counsel to represent all its members, another retained three separate counsel, and others represented themselves.

Victim Advocacy Organizations

We initially granted three victim advocacy organizations the opportunity for appropriate participation as a coalition: the Canadian Resource Centre for Victims of Crime, the Canadian Association of Chiefs of Police – National Working Group Supporting Victims of Terrorism and Mass Violence, and the Office of the Federal Ombudsman for Victims of Crime (OFOVC).

These groups were well placed to assist the Commission as Participants, given their extensive experience in supporting victims of mass casualties. The OFOVC later

requested to be released from the coalition in order to preserve its independence, which it stated could be jeopardized by working with victim advocacy organizations. We granted this request in our second Participation Decision Addendum, released on September 16, 2021.

The coalition assisted us in understanding the relationships among police, government, and victims of mass casualties through their participation in Phases 2 and 3 of our public proceedings. However, the OFOVC did not ultimately participate in the Inquiry because it did not have an ombudsperson in the role during the course of our mandate.

Health-Related Organizations

We granted the opportunity for appropriate participation to three health-related organizations: the Nova Scotia Nurses Union, the Nova Scotia Government and General Employees Union, and the Along the Shore Health Board. As on-the-ground community-based organizations with vast experience, each of these bodies had the potential to contribute significantly on issues related to how to keep our communities safer and healthier. Given the importance of their contributions and the breadth of their memberships, we decided that each organization should participate on an individual basis.

The Nova Scotia Nurses Union represents nearly 8,000 nurses, many of whom serve as community-based and emergency department nurses and were directly affected by the mass casualty. The union recognizes that violence in the community has an impact on those who provide care, including their member nurses, and through their participation they brought this perspective to the Commission's work with the aim of preventing future violence.

The Nova Scotia Government and General Employees Union (NSGEU) is the largest union in Nova Scotia and represents a number of occupational groups whose work is included in the mandate of the Commission. One of the union's members, Kristen Beaton, was killed in the mass casualty while on duty as a homecare worker. Another, Heather O'Brien, worked for the Victorian Order of Nurses for nearly 17 years before she was killed in the mass casualty. Many other members of the NSGEU who live and work in the same geographic area were exposed to the events and were deeply traumatized. The union involvement with a large number of workers in a broad range of workplaces brought a unique perspective on many matters in the Commission's mandate.

The Along the Shore Health Board is the volunteer community health board that serves the area from Onslow to Five Islands, Nova Scotia, supporting the geographic communities most affected by the mass casualty. By participating in our public proceedings, the board shared what it has learned about the events themselves and the ongoing impact on the individuals, children specifically, and families that make up their community.

Firearms Organizations

Access to firearms was an important aspect of our mandate and specifically referenced in our Terms of Reference. We granted the opportunity for appropriate participation to the Canadian Coalition for Gun Control and the Canadian Coalition for Firearm Rights to participate on aspects of our mandate dealing with access to firearms. After we released our decision, we received a late application from Canada's National Firearms Association. On the basis of their common focus, we directed that the association would participate in coalition with the Canadian Coalition for Firearm Rights.

The Canadian Coalition for Gun Control is a globally recognized non-profit organization that has worked to reduce firearm death, injury, and crime for 30 years. The Canadian Coalition for Firearm Rights is a volunteer organization that represents the Canadian firearm-owning community and has a vision to maintain, protect, and promote private firearm ownership. Canada's National Firearms Association has been in existence since 1978 and describes itself as "the largest firearms rights advocacy organization in Canada."

The Canadian Coalition for Gun Control, the Canadian Coalition for Firearm Rights, and Canada's National Firearms Association contributed to our work on the subject of firearms through their participation in Phases 2 and 3 of our public proceedings.

Justice Organizations

We granted the opportunity for appropriate participation to three justice organizations. We directed that two of these organizations, the British Columbia Civil Liberties Association (BCCLA) and East Coast Prison Justice Society (ECPJS), work together as a coalition on the basis that they shared a common perspective on the issues within our mandate. We granted a separate opportunity to participate to Nova Scotia Legal Aid based on its unique perspective and area of expertise.

The BCCLA is a non-partisan, charitable society based in British Columbia working both within that province and with a national scope. It has a unique perspective and expertise related to how powers of law enforcement agencies may be open to abuse, including how information is shared with other public entities such as the Canada Border Services Agency and intelligence bodies. Based in Halifax, East Coast Prison Justice Society is a non-profit, mainly volunteer-run organization made up of a collaborative group of individuals and organizations helping criminalized and imprisoned individuals. Finally, Nova Scotia Legal Aid (NSLA) represents people charged in criminal matters and people who are victims of violence in the areas of family, social justice, and criminal law. Its application stated that it is "uniquely situated to provide information on police decisions and behaviours during investigation, response to domestic violence situations, the court and other responses, as well as process in all stages of criminal, family and social justice proceedings."

The BCCLA / ECPJS coalition and the NSLA contributed to our work on issues related to both policing and violence through their participation in Phases 2 and 3 of our public proceedings.

Gender-Based Organizations

We received applications from nine gender-based organizations. All the organizations have a genuine concern about, and/or have an expertise on, issues of violence and, in particular, gender-based and intimate partner violence, which are an integral part of our Terms of Reference. Their applications demonstrated a varying degree of ability to satisfy the threshold of a substantial and direct interest in the Commission's mandate. Some of the organizations indicated that they would be willing to form a coalition with others. Taking into account these factors, we granted the opportunity to participate to eight of the organizations on the basis that they would work in three coalitions:

- Coalition I: Women's Legal Education and Action Fund (LEAF), Avalon Sexual Assault Centre, and Wellness Within.
- Coalition II: Feminists Fighting Femicide and Persons Against Non-State Torture.
- Coalition III: Women's Shelters Canada, Transition House Association of Nova Scotia (THANS), and Be the Peace Institute.

We also granted the Elizabeth Fry Society of Mainland Nova Scotia permission to provide written submissions regarding the intimate partner violence / gender-based violence aspects of the mandate. With locations in both Dartmouth and Truro, this society is a non-profit charitable organization that engages with vulnerable women and girls to foster re-integration, rehabilitation, and personal empowerment and to address the root causes of criminalization. As we moved further into the process, in addition to their written submissions, the Elizabeth Fry Society actively participated in additional Phase 2 and 3 activities.

GENDER-BASED COALITIONS

We directed that three groups of applicants with similar foci should participate in coalitions. The first coalition was composed of three groups:

1. The Women's Legal Education and Action Fund (LEAF) is a national non-profit organization and registered charity founded in April 1985 to advance the equality rights of women and girls in Canada as guaranteed by the *Canadian Charter of Rights and Freedoms.*
2. The Avalon Sexual Assault Centre is a Halifax-based non-profit that has been engaged in community-based work to eliminate sexualized and gender-based violence since 1983.
3. Wellness Within: An Organization for Health and Justice is a volunteer-based non-profit organization working toward reproductive justice, prison abolition, and health equity.

The second coalition was composed of two groups:

1. Feminists Fighting Femicide is an ad hoc group of Nova Scotia women formed in response to the mass casualty. They work to support survivors of male violence.
2. Persons Against Non-State Torture describes itself as supporting women who disclose and/or survive acts of torture and trafficking perpetrated within family relationships.

The third coalition was composed of three groups:

1. Women's Shelters Canada describes itself as "a Pan-Canadian organization with a mission to make ending violence against women (VAW) a priority."

A registered charity since 2012, the organization works with its members – the provincial and territorial shelter networks – to ensure that policies, legislation, and regulations are informed by the knowledge and experience of those working in the shelter networks.

2. Transition House Association of Nova Scotia (THANS) is a registered not-for-profit and charity representing 11 transition houses in Nova Scotia that provide crisis and transitional services to women and children experiencing violence and abuse. Three of its member organizations (in Truro, Amherst, and New Glasgow) have played and continue to play an important role in raising awareness, responding to the harms of family violence and intimate partner violence, and creating a network of transition and shelter services to the communities most affected by the mass casualty.
3. Be the Peace Institute is a non-profit working to address the roots and consequences of gender-based violence and advance systemic change for gender equity and social justice in Nova Scotia.

The gender-based organizations contributed to our work on gender-based and intimate partner violence in their participation in Phases 2 and 3 of our public proceedings.

Police-Related Organizations

We granted the opportunity to participate to six police-related organizations, each one knowledgeable about issues related to policing in Nova Scotia, an area that is at the core of our mandate. Members of some of the organizations were directly involved with this mass casualty. Four of the organizations were granted independent standing based on their unique perspectives. We directed that the Atlantic Police Association (APA) and the Canadian Police Association (CPA) were sufficiently aligned to warrant directing that they participate as a coalition.

The APA subsumed the former Police Association of Nova Scotia and plays an administrative and advocacy role for unionized municipal police officers, including those from Truro, Amherst, New Glasgow, Westville, Stellarton, and Charlottetown. In its application, the APA stated that the members it represents were in a position to provide policing to assist in preventing / limiting this mass casualty. The APA was in a coalition with the CPA, which is a national association that represents police unions and associations including 27 regional chapters at municipal, federal,

Aboriginal, and provincial levels. The CPA claimed to be the only organization that has the ability to speak from a national perspective to the operation of front-line police personnel in all types of policing.

The National Police Federation (NPF) became the RCMP's sole certified bargaining agent in 2019 for 20,000 regular members, reservists, and non-commissioned officers, below the rank of inspector. Many NPF members were directly involved in the RCMP response to the mass casualty.

The Nova Scotia Chiefs of Police Association represents police chiefs and the executive and management levels above the rank of non-commissioned officers in all municipal forces in the province including military police and other related law enforcement agencies. Commissioned ranking officers of the RCMP in Nova Scotia are also invited members.

The RCMP Veterans Association of Nova Scotia is one of 30 divisions across Canada representing retired RCMP officers. Its members hold a wealth of policing experience in Nova Scotia and insights that assisted the Commission.

The Truro Police Service, a municipal police agency located in Colchester County, has been serving the people of central Nova Scotia since 1875. Members of the service were working on April 18 and 19, 2020, and had some involvement in the mass casualty operations.

As a group, the police-related organizations brought national and local perspectives and experience to bear on a range of policing issues within our mandate. The National Police Federation participated in all phases of our public proceedings, while the other organizations assisted through their participation in Phases 2 and 3 of our public proceedings.

Guidance for Future Inquiries Regarding Group Applicants and Coalitions

The Commission's expectation was that each coalition would interact with the Commission and participate in Commission activities as one entity. This meant we expected to receive correspondence from the group, rather than individual organizations; that a coalition would send one member to represent it in meetings and proceedings; and that a coalition would provide one set of oral and written submissions. However, we found that the coalitions did not always adhere to our directions to work together as a group.

Where members of coalitions have not worked together before or participated in a public inquiry, it would be helpful to provide a document orienting them to the Inquiry's expectations.

In Phase 3 consultations, where the Commission identified that it would benefit from hearing the unique perspectives of coalition members, we invited coalitions to send more than one representative to participate.

In an effort to be more inclusive of the ways in which people might engage with our work, we chose not to have classes of "limited" or "full" participation. Nonetheless, some of the group Participants were expected to be engaged more in Phases 2 and 3 because of their focus on discrete aspects of the mandate. However, the Commission's delineation between Phase 1 Participants and Phase 2 Participants was not as clear as it could have been. As the process unfolded, it would have been helpful to all concerned if we had provided some more detailed guidance to them about the ways in which they could anticipate being engaged in the process, and at what points.

To ensure that the benefit of participation is maximized, inquiries should offer participants early guidance about expectations for their engagement.

Rules of Practice and Procedure

The Commission developed its Rules of Practice and Procedure (the Rules) following input from Participants, and we adopted them on August 16, 2021.[12] The Rules provided the framework for the Inquiry's public proceedings and were intended to ensure that everyone had a common understanding of the roles, processes, and approach.

Where possible, the Commission chose language that was less legalistic and more aligned with the mandate's direction to be guided by restorative principles. For

example, rather than refer to those individuals and groups who had a substantial and direct interest in the Commission's work as "parties," we used the word "Participants" to reflect the language in the Orders in Council.[13] That language also referred to the "opportunity for appropriate participation" rather than "standing."[14] We considered this language choice to be more in keeping with a non-adversarial approach.

In addition to choosing different language, the Rules also provided for ways of working that differed substantively from other legal settings. Rule 11, for example, set out our inclusive definition of public proceedings as including community meetings; expert, institutional, or policy roundtables; witness panels; and hearings.[15] Therefore, we referred to public "proceedings" rather than "hearings" to encompass a wider range of activities than witness testimony. Rule 25 outlined the broad test for what evidence could be received by the Commissioners as "any evidence they consider to be relevant and helpful in fulfilling the mandate of the Inquiry."[16]

Rules 26–30 dealt with Foundational Documents and explained that one of the reasons for them was to "facilitate streamlining of the Commission's oral proceedings."[17] The Rules set out what could be contained in the Foundational Documents and how Participants would have opportunities to contribute to their development.

Rules 35 and 43 focused on ensuring that any person or witness could fully participate in the Commission's work and made clear that the Commission would consider requests for accommodation regarding mode of testimony by witnesses on a case-by-case basis. This flexibility was offered at the discretion of the Commissioners.

Rule 52, which was about how witnesses would be questioned, reflected several aspects of the Commission's vision. First, although the rule set out that Participants may have an opportunity to question witnesses, this opportunity was related to a Participant's particular interests and, consistent with the Participant's role in an inquisitorial process, would be guided by direction from the Commissioners. The Rule referred to "questioning" rather than "cross-examination," which made clear that the focus was on contributing to the Commission's understanding of the evidence being provided.[18] This approach is discussed further in Chapter 4 in the "Questioning Witnesses" section.

Finally, Rule 68 demonstrated the Commission's commitment to inclusion by setting out that "[a]ny interested person" and not just Participants would be permitted

to make public submissions.[19] This wording invited witnesses, community members, and people across the country to contribute to the work of the Commission.

Our Rules of Practice and Procedure were designed to facilitate a shared understanding of the Inquiry's non-adversarial processes and how these processes would function in practical terms. Rules also provide a way to raise and resolve any differences of opinion about the respective roles and responsibilities of Participants, Commission counsel, and so on. We found, however, that a rule-based framework meant that counsel tended to default to more traditional, adversarial, and legalistic ways of working. In hindsight, using an alternative to rule-based language would have been more consistent with our approach. It would also have signalled more clearly to counsel the extent to which we were departing from more familiar proceedings.

> An alternative to a rule-based description of commission processes may help to overcome a tendency for counsel to default to adversarial behaviour.
>
> Investing time and energy into ensuring the procedural framework is well understood by participants will assist in developing shared expectations and help to avoid misunderstandings.

Notices of Misconduct

Section 13 of the federal *Inquiries Act*[20] states that commissioners of public inquiries must provide a notice of alleged misconduct where the commissioners may comment adversely on the conduct of an institution, government, corporation, or individual in its final report. Section 13 of the *Inquiries Act* states:

> No report shall be made against any person until reasonable notice has been given to the person of the charge of misconduct alleged against him and the person has been allowed a full opportunity to be heard in person or by counsel.[21]

A prime purpose of this provision in the *Inquiries Act* is to inform the recipient of the section 13 notice that they have a full opportunity to respond to the allegations

of potential misconduct. A notice of alleged misconduct is highly confidential. The notice is not introduced into evidence by the commission, nor is it circulated to other Participants.

Although public inquiries are prohibited from making findings of civil or criminal liability with respect to an individual, organization, government, or institution, it is clear that they have the power to make findings of misconduct with respect to the contents of their mandate.[22] Misconduct is not defined in the *Inquiries Act.* The Supreme Court of Canada has held that misconduct may involve "improper or unprofessional behaviour" or "bad management."[23]

Rule 64 of the Mass Casualty Commission's Rules of Practice and Procedure incorporates section 13 of the *Inquiries Act*, RSC 1985 c I-11. It provides:

> [I]f the Commissioners anticipate they may comment adversely upon a person's conduct in the final report, the person will have reasonable notice of the allegation and will be allowed a full opportunity to be heard.

Rule 65 states that "[s]uch notice will be delivered on a confidential basis to the person."[24]

Making adverse comments or findings was not the principal focus of the public Inquiry or the Final Report. To the extent that we made findings about what happened involving descriptions of the actions and decisions of individuals, our focus and findings were on how institutional, organizational, structural, and systemic factors shaped or were reflected in and through the conduct and actions of individuals.

Recipients of section 13 notices were informed that the Commission was prohibited by its Orders in Council and by statute from expressing in its Final Report any conclusion or recommendation regarding the potential civil or criminal liability of any person, organization, or institution. However, the notices made clear that the Orders in Council of the Commission required the Commissioners to "inquire into and make findings on matters related to the tragedy in Nova Scotia on April 18 and 19, 2020," "to set out lessons learned," and "to make recommendations to avoid such tragic events in the future."[25]

Recipients were told in their confidential notices that it was important to understand that the Commissioners had not reached any conclusions whatsoever in relation to the facts or submissions or whether any adverse findings or comments

would be made against them in the Final Report. Recipients were informed that the Commission was required by law to send the section 13 notice if such a finding *may* be made. Given the continual and transparent sharing of materials such as the Foundational Documents, the investigations supplementary reports, and the commissioned expert and technical reports, we anticipated that recipients would be unlikely to be surprised by the nature of the findings we might be expected to make in support of our eventual recommendations. In addition, we noted that counsel for Participants, in their questioning of witnesses and in their oral and written submissions, urged us to make critical findings about certain of the Participants and others involved in the mass casualty.

The Commission further stressed that the notice was to remind recipients that they had a full opportunity to be heard as required by section 13 of the *Inquiries Act* and as reflected in Rule 64 of the Mass Casualty Commission Rules of Practice and Procedure. A sample notice of alleged misconduct is reproduced in Annex A. Recipients of these notices responded to the Commission with submissions that were carefully examined and reviewed by the Commissioners.

Supporting Participation and Public Engagement

Introduction and Education

Even though commissions of inquiry have been happening in Canada since before Confederation, details of how they operate are not well known by the public, including many Commission staff members before they embarked on our work. A public inquiry is an official independent process designed to examine issues or events that have had a significant impact on the public. By their nature, each inquiry is unique, with a distinct mandate and specific areas of focus, audiences, and regional considerations. As we have said many times, an inquiry is not a trial. It is an inquisitorial process. If a civil or criminal trial asks what happened and who is

to blame, an inquiry asks what happened and why did it happen that way, so that we can learn how to improve as a society.

> Creating a better understanding of public inquiries in Canada in advance of future inquiries and outside the focus of a specific inquiry would serve the public interest. How and why are public inquiries different from one another? What can we learn from them?

In the early stages of our work, the public engagement and communications team examined other inquiries in Canada and internationally for context on how others had approached this challenge. The team also had to consider the restrictions in place for COVID-19, which significantly limited the amount of in-person activities possible in the communities most affected and in Nova Scotia broadly. Although nothing replaces the value of face-to-face conversations, the team worked hard to introduce the Commission and to provide information about our mandate and what to expect. This work involved a number of tactics and channels for connecting with people.

As we prepared for public proceedings, we wanted to ensure that as many people as possible were aware of the Commission and knew how to access information or ask questions. We recognized the complexity of the background information and the challenge of communicating it against existing narratives supporting conflict or conspiracy. We also knew that much of the material was dense and abstract, especially at this early stage. We tried to create options to make materials as accessible as possible. We provided information on many channels including radio, print, and online advertising, social media, email updates, and meetings with stakeholders. Where possible, we tried to create versions in accessible language, with supporting visuals of timelines, process, and Foundational Documents. Our engagement team also worked closely with the Commission counsel team to develop presentations for the proceedings to complement the information they were putting forward. We continually sought ways to help make information easier to access and to digest.

> Individuals access information in many ways. Identifying different methods for delivering information and revisiting whether it is being received in the course of an inquiry is important, particularly with those most affected.

The quantity of information during an inquiry can be overwhelming for everyone involved. Outlining how the document management and flow of information will work and when to anticipate "floods" of information will help people prepare.

The planning calendar is one of the most sought-after items. Any forecasting or certainty around planning that can be provided to participants is beneficial – and appreciated.

Like much of rural Canada, many of the most affected communities in Nova Scotia have limited internet access. We heard about the challenges communities had experienced in relation to the mass casualty and both internet and cell coverage. Given our focus on making the Inquiry inclusive and accessible – enabling all who were interested to take part, particularly given the barriers presented by the pandemic and the feedback during open houses – we were especially concerned about the internet availability to communities most affected. We directed the Commission's executive director to inquire about the provincial status in that region. She wrote to the Deputy Minister of the Department of Economic Development, emphasizing the importance of providing ways for full participation in the upcoming proceedings and urging the government to continue and, indeed, accelerate that work so the public would be able to access the Commission's work. She offered to meet with them to share more about what we had heard and learned. In a letter dated December 15, 2021, the Deputy Minister responded with an update on the rollout of the implementation of internet in the area and stated that the Province was working as quickly as possible to close the gaps in the provision of high-speed internet in Nova Scotia (see Appendix F).

To help address this potential barrier to the public accessing our process, the Commission sent direct-mail postcards early in our work to people in the affected communities, introducing the Commission and sharing the website, email address, and phone number. We sent another direct-mail postcard to every household in Nova Scotia at the beginning of public proceedings. This mailing served multiple purposes, among them letting people know how to follow the Commission's proceedings and alerting them that the conversation about the mass casualty, including media coverage and public discourse, was about to increase. In addition to these mailings, the team also arranged for ads in local newspapers and on local radio stations, plus targeted boosted posts on social media.

We developed the Commission's website as a central platform for information sharing that would help people to understand more about how inquiries work, our mandate, and what to expect. The website included answers to FAQs and a "key terms" section. As Commissioners, we recorded a video to introduce ourselves and to share our goals and plan for the Commission. The website grew as the Commission's work progressed, sharing key information, documents, and webcasts of public proceedings. New and important information was also promoted on the Commission's social media and other communications channels.

Awareness-building efforts proved successful, as website traffic, phone calls, emails, submissions, and other kinds of public contact increased in response to the Commission's mailers and ads. Although without formal measurement it is difficult to gauge how well these approaches built public understanding, we can say that throughout our engagement activities many people responded to survey and submission requests, provided forward-thinking recommendations, and made suggestions that demonstrated a thorough understanding of our Inquiry and its processes. At the same time, we also received ongoing feedback from people who expected the Commission to assign blame and make liability findings, contrary to our mandate.

Communications Planning

At the outset, we developed a communications strategy to support the Commission in fulfilling its mandate as outlined in the Orders in Council. The communications team created an approach and recommendations for engagement with all stakeholder audiences, including the public, to define priorities and try to provide information about a complex process. Communications would support the Commission in delivering on its mandate by proactively engaging key stakeholders and the public to build support, confidence, and trust in the process. Ultimately, our communications strategy was designed to build a foundation of understanding about the inquiry process and then for the recommendations and findings of the Final Report. It would evolve in step with the Commission's phased approach based on inputs and feedback from the Commission teams, stakeholders, and the public.

Overall communications intention: To provide clarity around the causes, context, and circumstances that led to the April 2020 mass casualty in Nova Scotia and make meaningful recommendations to help make communities safer in Canada.

Our communications goals were to instill trust and confidence through a transparent and independent process – one that was undertaken with compassion and driven by a commitment to provide meaningful recommendations to help make communities safer in the future. Communications and engagement planning aligned with these values.

In developing a plan for communicating the Inquiry's work, the team undertook research and reached out to experts. Some of this research included a review of inquiries held across Canada and around the world and how they communicated to specific audiences. We also asked journalists for their input and conducted media and social media scans to understand current themes and focus areas around the mass casualty.

Insights

Highlights of Media and Social Landscape Review

- *Social and traditional media activity was high and sustaining.* In the first four months after the mass casualty, on average per day, there were 750 social media mentions and more than 100 online news mentions of the mass casualty. Between August 2020 and January 2021, there were approximately 100 social media mentions and 20 traditional media mentions per day, representing the adjusted baseline of volume following the initial spike of activity associated with the mass casualty itself.
- *Niche media outlets and related social media activity carried a significant part of the conversation.* Although major media outlets and social media platforms carried a lot of conversation, we saw a sustained activity driven by groups and individuals who were focused on the mass casualty.
- Overall, social media conversations and traditional media coverage indicated a general erosion of trust in public institutions following the mass casualty.

Insights from the Review of Other Inquiries

Other inquiries reviewed included the National Inquiry into Missing and Murdered Indigenous Women and Girls, The Government of Canada Response into the Investigation of the Bombing of Air India, the Walkerton Inquiry, the Ipperwash Inquiry, The Royal Commission of Inquiry into Abuse in Care (New Zealand), the Grenfell Tower Inquiry (UK), and the Truth and Reconciliation Commission of Canada.

Reviewing the communications approaches and outcomes from these inquiries helped guide our planning around public engagement and communications. Although many inquiries did not have the same platforms or levels of engagement, it was useful to understand how they approached engagement.

Media Input

We received helpful feedback from members of the media:

- *Access to information was a top priority.* Feedback from the media consistently cited a lack of access to information as a concern when reporting on investigations or inquiries generally. Some members of the media cited getting documents the day of a proceeding or even an hour before it began and the challenge of reviewing and reporting while proceedings were underway.
- *Content for multi-channels.* Media channels vary, so it was important to consider how content would be shared in print, on the radio, on TV, or online. Video and audio clips are becoming increasingly important.
- *Access to proceedings room and coverage*. Discussions were ongoing during COVID-19 restrictions, and many media events were taking place virtually. Media outlets were accustomed to working with pool cameras (one camera filming and sharing footage with multiple outlets) and suggested this technique would work for the Inquiry. When possible, media wanted to be on-site for public proceedings.

Communications Objectives

Based on the above input, we developed an approach that included these objectives:

- Lay the groundwork for an understanding of the inquiry process.
- Engage priority audiences and media.
- Educate and manage expectations as we undertake our work.
- Put people at the heart of our work, with a priority to do no further harm.

Communications Priorities

To achieve the communication objectives, we identified the following priorities:

- *Use proactive, direct, and integrated communications to build public understanding, confidence, and trust in the inquiry process:* Understand and anticipate key communications milestones throughout the inquiry process to ensure integrated and thoughtful communications to our audiences at every step. Meeting the public where they are and having a diverse tactical approach to engagement and proactive communications are vital to building understanding and trust.
- *Communicate with care:* Lead with a trauma-informed communications viewpoint. Focus on ensuring those most directly affected are the first to know information through channels that best support their needs.
- *Media transparency – make it easy for the media to stay informed:* Be responsive and go directly to the media to build relationships and to provide accurate information for the benefit of families and communities.
- *Make use of public engagement to support the findings of the Inquiry:* Establish open, transparent communication to engage and inform the public on the Inquiry's findings, with the longer-term aim of public policy change.
- *Make every word matter:* Be mindful of the tone of each communication and consider multiple perspectives.
- *Make it relevant:* Develop content to meet audiences "where they are" through channels that best support their needs.
- *Think outside the box:* Explore and implement creative ways to educate and engage stakeholders in the process and topics in the mandate of the Inquiry throughout the timeline of Commission.

Establishing a Name and Visual Identity

From the outset, the aim was to instill trust and confidence through a transparent and independent process, one that was undertaken with compassion and driven by a commitment to better protecting and serving all Nova Scotians, and indeed all Canadians, in the future. The name and visual identity would carry into the look and feel of all of the materials produced by the Commission including, among many others, reports, the website, social media profiles, and community outreach materials, and were therefore carefully considered.

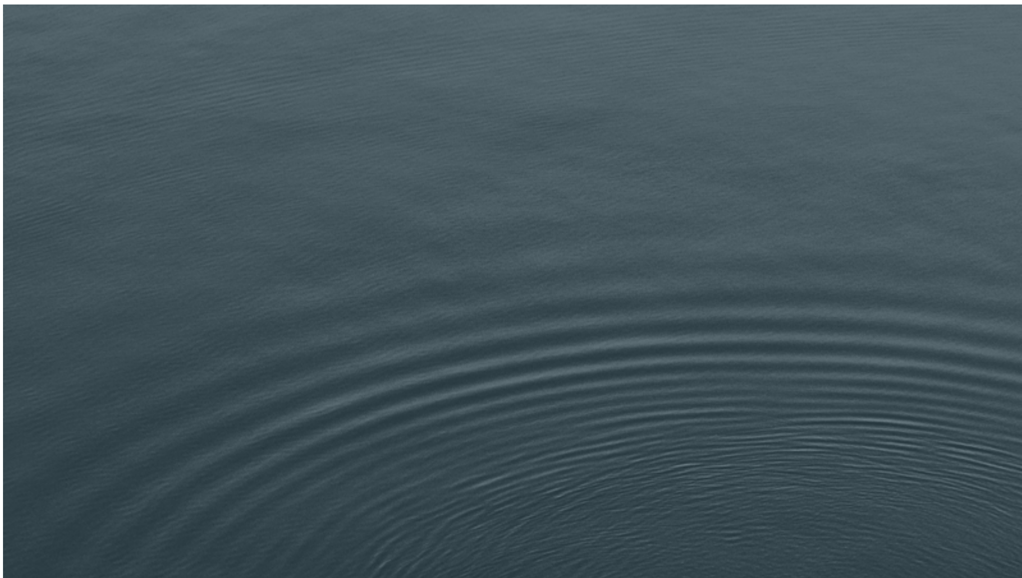
The official name that we used for the Commission was "The Joint Federal / Provincial Commission into the April 2020 Nova Scotia Mass Casualty," while the shortened version (for regular use) was the "Mass Casualty Commission." Why adopt this shorter name? If we used only the longer version, it increased the chances of it becoming an acronym or the name being determined by others (e.g., "Nova Scotia Shooting Commission.") Our shortened version focused on the intention of keeping the Inquiry accessible. We also considered that most references at that point referred to the events as "the Portapique shootings." We recognized that the events had happened in many communities; damage was caused in many ways, not just from shooting; and there was a wide impact on so many people. We wanted to make sure the name was inclusive. **We also made a commitment that we would not abbreviate the name (i.e., MCC), out of respect for those most affected.**

Before a website could be established, an identity or "look and feel" needed to be created. It was determined the identity should reflect the values of the Inquiry: independence, respect, and transparency, as well as compassion, thoughtfulness, integrity, and credibility. In creating the visual identity, we again reviewed other inquiries across the country and around the world. We knew a lot of the Inquiry would be viewed online.

We wanted to make sure we showed respect for the importance of the Inquiry and dedication to delivering policy recommendations that will have a positive impact in the future. It was important that the design reflect the independent and serious nature of the Commission – it should not look like an arm of the provincial government, the RCMP, or other institutions. We wanted materials to be consistent, simple, and accessible throughout the process.

A few notes on the identity development: Each word had its own line and with equal weight to reinforce the gravity and impact with independent respect. Symbolically, the three parallel lines represent the Commission's broad areas of focus:

Past | Present | Future. The ripple image we used throughout the Inquiry was in recognition of the many, many people and communities, in addition to those most affected, on whom the mass casualty had a significant impact. This concept works to visually communicate that impact.



The simple design was effective for the Inquiry in creating something familiar and easy for people to recognize. We received positive feedback on the design throughout the Inquiry. Once the design was established, we created templates to generate materials in a straightforward manner and to ensure visual consistency.

First Outreach

We knew people were seeking information quickly after the announcement of the Commission. An office was not yet established and email accounts were not yet set up. We arranged for a letter to be sent from us to families of the deceased at the outset, working through the provincial Victim Services Program, letting them know the Commission was working to set up an office and website and asking if they wanted to receive regular updates from us. We also asked if other family members should be included. Once the website was developed at the beginning of December 2020, the first people we advised of it were the families most affected.

With the introduction of the website, we advised the media and asked about interest in receiving regular updates. Although focused on hiring a team and planning our work, we also gave our attention to providing regular, consistent updates as soon as we had information to share. We were aware of how little information people had received and wanted to provide as much as possible, even in the early days. We also heard from families and Victim Services that many families were dismayed to learn of updates previously via the media, rather than hearing new information directly from officials first. As noted earlier, we notified family Participants of any updates before sharing them with media or posting them publicly.

Doing the outreach early and providing updates helped us to develop distribution lists. We wanted to provide information directly. Our lists grew with ongoing requests to receive the updates from families, the media, and stakeholder groups.

> At the outset of an inquiry, spending time with participants on roles, mandate, and expectations would serve everyone well. It is also worth taking the time to identify the risks of contentious or adversarial behaviour and predetermining the steps to mitigate and rectify it if it arises.
>
> Co-create communication channels with participants (i.e., families) at the outset, so they receive the information they seek directly and in a timely manner and have a way to request information on matters such as logistics. Consider a role such as a family liaison or navigator who can assist with information such as mental health, proceedings, media inquiries, general information, logistics, and funding.

Commitment and Approach to Communications

Communicating the Process

The mandate and deadline of the Inquiry were set out in the Orders in Council. An inquiry is a complex process with rules, procedures, interdependencies, timelines, and required outcomes. The design of the Inquiry drew on practices from many past inquiries and required a trauma-informed approach. We needed to find ways to lay the groundwork – to articulate at the outset the phases, the timeline, and the rules and share them with Participants and the public. We sought to do our work in a deeply relational way, to build inclusion, understanding, and access. Understandably, the general public was primarily focused on "what happened." There was some recognition of the complexity of the entire mandate, but the primary focus was on getting answers to what happened in those 13 hours from Saturday evening April 18 to Sunday morning April 19, 2020.

Community Accessibility and Outreach

General Phone Line, Email Address

As noted, it was important to reach out to people across a variety of channels to ensure they knew about the work of the Commission and how to pose questions, provide potentially valuable information about the mass casualty, or share their experience.

The Commission established and maintained a 1-800 telephone number as well as a local Nova Scotia number and a general email address (info@masscasualtycommission.ca). As of the end of October 2022, our public engagement and communications team had responded to more than 700 emails and more than 230 phone calls from the public. Many members of the public also used these avenues to provide input about our process.

The phone line went directly to voicemail, and two people monitored messages and passed them on to the appropriate person to respond within 24 hours. Maureen Wheller, the community liaison director, returned the majority of the

phone calls and often followed up if the caller had a question she could not answer immediately.

The communications team monitored the general email address, rather than use an automatic reply. Members of that team drafted responses in consultation with a representative from each Commission team, depending on the questions. The majority of emails received responses within a week. The response time did vary according to the complexity of the questions or the availability of the appropriate team member. In busy times for the Commission, some responses may have taken longer. We developed guidelines for determining which emails received responses – the vast majority of them did. Following the guidelines, emails that were excessively aggressive or rude did not receive responses, nor did those selling services or unrelated to the Commission.

Creating a way for communities to provide their experiences, particularly when they have experienced significant trauma, is important.

Tracking the information that people are seeking enables relevant responses to public questions.

Listening to community and public questions shapes the communication outreach and requires agility and responsiveness. Plans may need to change to meet the needs.

One-on-one conversations and group sessions provide an opportunity for specific questions to be heard and answered. They require more time but are valued.

Correcting inaccuracies in media and social media is time intensive but important.

Communications efforts are factually focused on relaying information rather than persuading or pointing to conclusions. Our communications efforts let media know of information available and decisions that were made and why. But they did not actively try to shift narratives or advance points of view.

Overall, the general phone line and email address were widely used and valuable to both the public and the Commission. Information received varied from making the Commission aware of technical issues during proceedings to providing information for the investigations team to look into. These channels also gave the Commission

insight into what was top of mind for the public or areas that potentially needed additional information or education. Many people used these channels repeatedly and were able to share information they received within their networks.

Site Visits

In the summer and fall of 2021, pandemic restrictions had eased in Nova Scotia, allowing the Commission teams to do more on-site as well as greater community outreach. We invited the public to contact the Commission if they felt they had any information that would be important to the investigation and included this invitation in all communications with the public at the time. Commission staff members had many conversations following up on information provided by members of the community.

As we discuss below, the Commission's investigations team made a number of visits to the communities most affected, specifically the areas of the crime scenes to gather information and images to inform its investigation and for use during public proceedings. The Commission was aware that its presence in places that had experienced such trauma could be difficult for some community members. As an example, we wanted to avoid someone being frightened if they saw a stranger coming out of the woods near their home. To avoid such a situation, the communications team worked to make sure a number of measures were taken before and during these visits so community members would be aware of what was happening.

In advance of a site visit, the Commission posted community notices on its website and social media to let people know dates and approximate times and locations. This information was also provided to local radio stations, and phone calls were made to area businesses or organizations that were community hubs or places where people would get information. During these visits, teams on the ground used ground signs or sandwich boards to indicate they were working in the area, with contact information if there were questions.

The communications team also coordinated with media in advance to limit the media presence in the communities. Media were co-operative, and they coordinated to send one pool camera or journalist who would share footage of the Commission at work, thereby limiting the number of on-site cars and cameras.

The visits proceeded with very few issues. The team did receive feedback from some community members who felt the signage in the area was distressing and

asked that it be removed. The investigations team complied. As always, when working with those most affected, the priority was to keep people informed and to provide choices and control about how they interacted with the Commission.

Open Houses

Also in the fall of 2021, the Commission hosted six public open houses. These events offered an opportunity for members from affected communities to meet members of the Commission teams, learn more about the Commission, and ask questions.

Locations included Debert, Milford, Millbrook, Truro, Wentworth, and Dartmouth, and times were varied to offer community members a range of options. The information being shared was the same at each location, so the public was encouraged to attend whichever event worked best. Station-based information exhibits allowed attendees to engage with the specific topics that were of greatest interest. Community members could move at their own pace, ask questions of Commission staff, and, through comment cards and surveys, provide feedback on how they would like to hear from the Commission in the future.

The drop-in format allowed community members to attend at any time during the two-hour events, according to their schedules. Print materials were available for attendees to take home to their families and friends.

Staff at the open houses represented the Commission's legal, investigations, research and policy, mental health, and public engagement and communications teams. Team members were available for extended private conversations with community members who may have wanted to provide information on the record.

Each venue offered a separate space used as a dedicated wellness room that was available for anyone who needed a moment alone. To provide mental health resources, the wellness room offered a quiet space, counselling if needed, and reading materials or activities such as puzzles.

Media were permitted on-site for the first 30 minutes of each event and then would leave or stay outside to be respectful of attendees.

More than 100 people attended the open houses and feedback overall was positive, though some people had expected to find more information about what happened during the mass casualty. We explained our mandate was to find out what

happened and that answers would be provided throughout proceedings and in our Final Report. Discussions at these open houses helped the Commission understand how little information had been shared with the community prior to our Inquiry and the high level of interest and concern, helping us to plan future communications to the public.

The Commission also observed the significant levels of grief that the community felt and understood that people wanted to share their experiences. These shared experiences demonstrated the ripple effect that the mass casualty had throughout Nova Scotia and beyond. Input from the open houses would inform the Share Your Experience survey process, which we discuss in Chapter 4.

Community Presentations

In addition to the open houses, in the summer and fall of 2021 the Commission made a series of presentations introducing our approach. These presentations were available on request to any organization, and the Commission also offered to provide the overview presentation, including a question period, to community groups. Led by the public engagement and Commission counsel teams, these presentations, some of which were later webcast or posted publicly, were made to the Nova Scotia Federation of Municipalities, the Millbrook Band Council, the Halifax Regional Municipality, and the Truro Rotary Club, among other groups. These presentations were part of the overall effort to ensure that community leaders heard directly from the Commission about its independent investigation, had the opportunity to ask questions, and knew how to contact the Commission if questions or concerns arose in their communities.

At the same time, we also held coffee meetings in the communities with leaders and members to identify potential venues for community engagement, to understand how they received their information, and to receive any general advice they wished to provide.

The direct outreach and presentations helped us to connect with community members and leaders. Along with explaining the process of the Inquiry, we were able to answer questions. Many people appreciated the opportunity to learn about the Inquiry's work, what to expect and how they could contribute in the next phases, and what they could do once recommendations were developed.

Stakeholder Outreach / Engagement

Community and stakeholder outreach remained a major pillar of the work of our public engagement and communications team. As we started to get a clear picture of the information the Commission would be sharing through public proceedings, it became apparent that it was even more important to engage with community organizations, media, and all levels of government. Our goals were to inform them about what to expect and to hear what would help their communities to prepare for their involvement in the Commission's work.

Integrated Support Working Group

While careful to maintain our independence, communications, community liaison, and mental health team members joined the Integrated Support Model Working Group, led by the Province of Nova Scotia, which was an intergovernmental and interagency working group established to build system capacity for more coordinated and integrated communications, supports and services, and processes affecting families and others most affected by the mass casualty. The working group was intended to provide key insights about structural impediments and to work in more integrated ways across systems.

One of the group's objectives was to play a convening and facilitative role with respect to information sharing. The intent of the group was not to compel information sharing, but to provide an opportunity to inform respective decision-making on coordinated communication approaches and provide a more coordinated and integrated approach to support the long-term needs of families.

Members of the group included representatives from the following organizations:

- Nova Scotia Department of Justice: Victim Services (Community Support Navigator Initiative) and Restorative Initiatives Unit
- Nova Scotia Medical Examiner Service
- RCMP Family Information Liaison Unit
- Nova Scotia Department of Health and Wellness: Mental Health and Addictions Services

- Nova Scotia Department of Education and Early Childhood Development: SchoolsPlus
- Office of Citizen-Centred Approaches
- Mass Casualty Commission

These sessions helped to provide a better understanding of services being offered in communities as well as general feedback (e.g., on the impact on teachers at schools). Discussions, kept at a very high level to maintain independence and confidentiality, provided insight into how many departments within the provincial government were connected to the mass casualty and the need for a coordinated response. When it comes to addressing systemic issues, if information exists in so many places it can remain in silos, without any deliberate effort made to coordinate it.

Community Sector Meetings

In early 2022, the Commission team did broad outreach to a large number of community groups and invited them to attend meetings with other organizations having shared interests. These community sector meetings included groups focused on supporting youth, those based in the communities most affected, mental health organizations, organizations with broad community support such as the United Way and the YMCA, and groups supporting women. Initially, we intended to ask about areas of interest in the work of the Commission. The open houses helped us to gain insight into how little information people had about the mass casualty and our work. At that time, the Foundational Documents were under development and we were aware of the quantity and intensity of information that lay ahead. We were also aware that this information had the potential to impact many people after so much time had passed and that we would start sharing it in February 2022, in the dark and unfriendly months of winter.

Members of the Commission team met with these groups to gather their input on how best to prepare the public for the upcoming proceedings. We focused on letting community groups know that difficult information was coming; we wanted them to be aware of that so they could prepare to help their communities as needed. We also sought advice about things we could do in advance.

Engaging with community sector groups early provides insight and feedback for best ways to engage with broader and specific communities.

At our community open houses, we heard how little information was known about the mass casualty. We recognized the sensitivity and the quantity of the information that would be coming with the Foundational Documents during a dark and wintery time of year. We worked with mental health organizations, community sector groups, and the media to give advance notice about the difficult information to come and, drawing on their input, suggested ways to prepare.

Community organizations reached out to their communities directly with offers and advice and expressed appreciation for the opportunity to prepare.

Connecting with community sector organizations creates an opportunity for co-operative outreach. Groups appreciate the opportunity to connect, learn, and share observations. This kind of connection also sets up the opportunity to later connect on the recommendations coming out of the Report.

Inquiries may need to proactively engage those most directly affected. We heard and learned that many people experienced significant trauma, but they did not want to put themselves, their experiences, or their needs ahead of anyone else.

Encouraging mental health support is a complex matter. Connecting to those services is especially complicated when the system is in crisis. We learned how community sector organizations and the Province's services were often challenging to navigate and to access. Some people thought the Commission was providing services. Others had stigma attached to mental health and "crisis" services. Others told us that the caregivers were in significant need of support. Some people told us they could not get access at all.

While we were trying to develop trauma-informed approaches, we were hearing from communities in crisis that were not necessarily getting the services to address their needs or a path forward.

Community groups told us that it would be more helpful for us to point people toward the 211 services line than to the Province's crisis line or a variety of other support options. From their perspective, one clear direction was best – and the 211 line helps navigate a long list of services, including community service organizations and the Province's mental health crisis line. This advice coincided with community feedback that not everyone considered themselves in crisis. We heard from

some about the stigma related to accessing mental health services, particularly in rural areas. Based on this input, we worked with 211 and started directing people to that helpline, which could assist in directing people to various services within the Province and community.

In advance of the beginning of public proceedings, many of the stakeholder meetings led to requests for further meetings with other groups. We agreed to all of them, without hesitation. The more people who were aware of our upcoming work and willing to provide us with input and feedback, the better. We met with a number of groups, among them a network of organizations focused on youth and staff of the Nova Scotia Health Authority in the Colchester region, and we held an open meeting for chief administrative officers and elected officials across Nova Scotia, coordinated with the Nova Scotia Federation of Municipalities.

Community group leaders appreciated these meetings. They told us they valued group discussions, which were not a common occurrence, and having the time to prepare their teams. They suggested we provide calendar updates so they could continue to inform their teams. We also prepared an information package for the community sector groups to share with their staff or other partners or individuals (see Annex A).

First Responder Meetings

We knew first responders who were directly involved and affected by the events of April 18 and 19, 2020, would have unique perspectives and experiences. Listening to them and understanding their perspectives was necessary for the Commission to understand what happened and how first responders have been affected.

The Commission held five virtual introductory meetings with first responders (including police, fire, emergency health services, and others) in July and August 2021. We extended invitations to any first responders in Nova Scotia via Participants, unions, and stakeholders. Attendees had the option to attend individually, as part of a group, or with a support person.

These meetings provided an opportunity for us, the Commissioners, to introduce ourselves as we had done in our initial meetings with the families of the deceased. We were able to share information about the Commission's work, including an overview of the mandate, what to expect, mental health support, and how to contact the Commission. We then heard initial perspectives from the first responders.

They provided input on the Commission's work and shared how they wanted to engage with us.

In retrospect, although Commission counsel were in contact early on with counsel for both management and the unions of first responders, it would have been helpful to open a dialogue with first responders themselves, concurrent with our work, to develop connections with the families, to convey information, and to encourage them to engage with the Commission's work. Some first responders shared the misconception that the Inquiry was more like a trial that would make liability findings and were therefore wary of co-operating. Some did not feel their perspectives were well represented by either union or management.

> Future commissions should look for opportunities to engage with these individuals directly, recognizing that many of them are not just first responders but also community members and among those most affected.

Although we hoped for higher attendance, these meetings helped us better understand the impact of the mass casualty on first responders and provided us with guidance on how they could share their perspectives and lessons learned to help us develop our process and our recommendations. We are grateful to all the first responders who gave us their time.

Government

We also organized meetings with elected officials and government staff to ensure all levels of government had accurate and timely information about the Commission's work. On multiple occasions throughout our work, the Commission team briefed members of municipal councils from across the province, and briefed deputy ministers and the provincial caucus of each of the three parties, including the premier and the leader of the opposition, and members of Parliament representing Nova Scotia. The Commission team also ensured that stakeholder updates went to constituency offices and offered elected officials and public servants updates at their convenience and welcomed them to reach out if they or their constituents had any questions.

We continued these meetings throughout our work. At key moments, for example the release of the Interim Report, or in advance of proceedings related to a particular area of work, we sent briefing invitations to a broad group of recipients. In particular, in advance of the proceedings that focused on gender-based and intimate partner violence, we met with organizations, including some Participants, that provide support to women and children who are survivors of these types of violence. These meetings were important so that people working in communities could inform survivors of what to expect from the Commission and prepare to provide support. We gained valuable perspectives from those who attended these meetings and observed co-operation among community groups to prepare supports and responses. Some of these discussions also led to further community outreach, which we will cover in Chapter 4.

It is these individuals and organizations who we hope will champion and, in many cases, implement the recommendations after the Commission has concluded its work. It was essential that their voices were reflected throughout our work. Their engagement and dedication were instrumental to our process.

Stakeholder Updates

Soon after the Commission was established, we began sharing regular updates via email and on our website with those most affected, Participants, the public, and members of the media. These updates, samples of which are included in Annex A, provided information about the Commission's progress, recaps of work completed and milestones delivered, and opportunities to engage and take part in our work. To help people learn more about public inquiries, we also included explanations of key terms and processes important to our work, including the role of Participants, Foundational Documents, and different types of public proceedings.

We built our initial mailing lists in consultation with those most affected, representatives of community organizations, and members of the media, asking people if and how they would prefer to hear from us. Updates were emailed to those most affected and other Participants before we shared them with the media and the public, so that if there was newsworthy content they would hear it from the Commission first, before seeing it published by the media.

We learned from families that holidays and the 18th and 19th of each month were challenging days. We made extra efforts to avoid these days when we scheduled

events and when we sent emails. We also tried not to send anything on evenings or weekends. The timing was not always perfect, since we were also trying to balance getting information to those most affected as soon as possible. The timing often depended on many factors, including internal sign-off, incoming correspondence from Participant counsel, document disclosure, or scheduling changes. As noted earlier, we always sent information to families and those most affected first before sending to other distribution lists.

Before the start of proceedings, we sent updates on a regular basis or whenever we had new information to share. During public proceedings we began sending weekly updates with information about what we had focused on in proceedings that week and what to expect in the coming week, including the schedule and the names of witnesses.[26]

We drafted updates with input from all the Commission teams, including our mental health experts, to ensure we were providing a holistic view of our progress and continuing to share appropriate guidance around wellness supports and services. In response to feedback from readers, over time we continued to refine the format of our updates, introducing summaries and subheadings to assist with ease of reading and navigation.

In addition to emails, we posted all updates to our website and shared links on social media. Over the course of our work we shared more than 70 updates, including our regular emails, community notices, and media statements. More than 970 people signed up to receive updates, including those most affected, interested members of the public, and members of the media.

> Providing updates directly was a useful way to provide consistent information. We received regular requests for additional names and saw extremely high engagement rates with the updates.

Website and Social Media

Intentionality of Design

We established our bilingual website to provide stakeholders not only with an educational space to learn more about the Commission but also with an accessible way to engage with public proceedings. When a user visited the website for the first time, a pop-up would appear on the user's screen with the following content warning:

> Some of the information within this website may be disturbing or upsetting for some visitors. This website deals with information about events that included gun and other violence, including gender-based violence and intimate partner violence. If you need to leave at any point, there is a "quick exit" button at the top of the website. This website also includes some suggested resources, should you be in need of support.

Keeping in line with the trauma-informed approach, it was crucial that we gave people the option to navigate away from our website. Should they choose to continue, the "quick exit" button referenced in the initial warning remained always available, no matter what page the user was on. We set up a similar option for particularly disturbing content on the website. For example, we did not want users to accidentally click on a link on social media or another virtual forum that would potentially include graphic material without having a clear option to decline the viewing.

Educational Content

It was important that our website acted as a place where the public could go to find answers to their questions. Through the sections on our website, we wanted to educate people on topics such as the purpose of the Commission or the differences between civil and criminal trials and public inquiries. We had web pages designed to inform readers about how our Foundational Documents were created and the role of Participants in the inquiry process. Essentially, if an action needed

to be carried out, or a tool needed to be created, we wanted to have that language available on the website to convey, "This is exactly why we are doing this."

We knew that public proceedings would move quickly, and as the phases of our work changed, so did the sections of the website. For example, we created the section on the roundtables only after Phase 1 of the public proceedings had concluded. Once we began to explore the related issues outlined in our mandate, we added a variety of pages to the website, with the educational section on the roundtables being one of them.

In summary, as proceedings happened, the website evolved to help inform the public on the different activities being conducted and the issues being discussed. The website was the hub for all information. Although we knew at the outset that this would be the case, we did not fully appreciate the number of documents or the functionality we were going to want to build into the website. We worked to get all information, including all documentation, posted to the website as efficiently as possible. The total number of documents on the website was over 7,400.

With our focus on transparency and making information accessible, we regularly assessed what questions were being asked, what we could provide to clarify our process or answer questions, or if there were there any ways we could make it easier for people to access documents and information. As of November 2022, there had been over 189,000 users to the Commission website, over 1.7 million page views, and over 390,000 file downloads.

> We suggest that the inquiry website remain active for as long as possible after the release of the report. This would ensure accessibility to the wealth of information the website contains for the benefit of those striving to improve community safety.

Social Media

We created our social media accounts to proactively share information with stakeholders and help them engage with our work. We also wanted to instill public trust

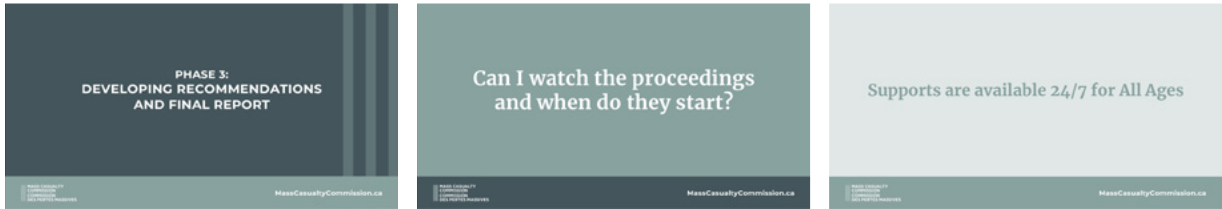
and cultivate conditions for the eventual recommendations to be understood, accepted, and implemented.

A number of key components were considered. Having a presence on Facebook and Twitter allowed us to be present to share information where we knew stakeholders were present (go to where people were), but we knew that monitoring uncensored comments and misinformation is challenging. These platforms also provided the option to boost posts for a small fee, creating opportunities to reach a wider audience. All language drafted for social media needed to be clear and engaging, while following our established lexicon and trauma-informed approach. Our social media presence was never to be used as a marketing tool aiming to raise the profile of the Commission, the broader team, or anyone officially associated with the Inquiry. It focused on providing information and an avenue to reach out to the Commission.

> Social media requires careful consideration for inquiries. Not all platforms present effective ways to engage or communicate, given the complexity of inquiries or the emotional nature of some topics. However, it can be a source for sharing, correcting, and engaging with key audiences. Clear intentions and parameters must be considered at the outset.

In March 2021, we officially launched our English-language Facebook and Twitter accounts, which would operate in line with a two-phase social media strategy. In phase one, our social media accounts were used mainly to broadcast announcements and milestones, whereas in phase two the accounts were used to engage stakeholders by providing more details of the Commission's work. We also established social media guidelines, which we posted on the Commission's website.[27] We created French-language accounts for Facebook and Twitter in April and May 2021. At the time of this Report, the follower count and engagement rate for the French accounts remain low.

We created graphics not only to accompany social media posts but also to help categorize the types of posts being published (the darkest shade of the theme colour for milestone announcements, a medium shade for content meant to inform and engage users, and the lightest for sensitive material such as the promotion of wellness supports). All graphics were created with the look and feel of the Commission in mind.



In January 2022, social media accounts in both official languages were connected to Sprout Social to assist with scheduling content and developing reports to gather insights to share with the rest of the team. During proceedings, the communications team posted to Facebook and Twitter at the beginning of each day with a link to the day's agenda and webcast, and again when proceedings adjourned. Additionally, Twitter was used to inform the public in real time when proceedings were breaking or starting again on one thread. The events of proceedings would be tweeted throughout the day within one thread, essentially creating a mini-record on our social media channel of what took place during public proceedings.

Social Media Guidelines

The Commission's social media platforms were created to inform and engage, recognizing that while open dialogue is important, not all conversation is respectful. We established guidelines to ensure a consistent lens would be

applied to social media content and that activity on the Commission's platforms aligned with the Commission values of independence, respect, and transparency. The guidelines, which are included in Annex A, applied to users when engaging on the Commission's pages or with content published or shared by the Commission's accounts.

We made it clear that we would remove published content on any of our digital properties or channels that did not align with our social media community guidelines. To remain transparent, we contacted users directly to let them know if any commentary did not follow the guidelines. This action was rarely required.

Account moderators did not interfere with criticism about the Commission if comments followed the guidelines. In some instances, Facebook automatically hid comments that might not have adhered to the platform's own guidelines, which are separate from those of the Commission. Whenever the moderators of the Commission's social media accounts noticed this taking place, they made the comments public again. It was never our position to silence the opinions of the public. If a user followed our guidelines, their post or comment remained in place.

Social Media–Monitoring Insights

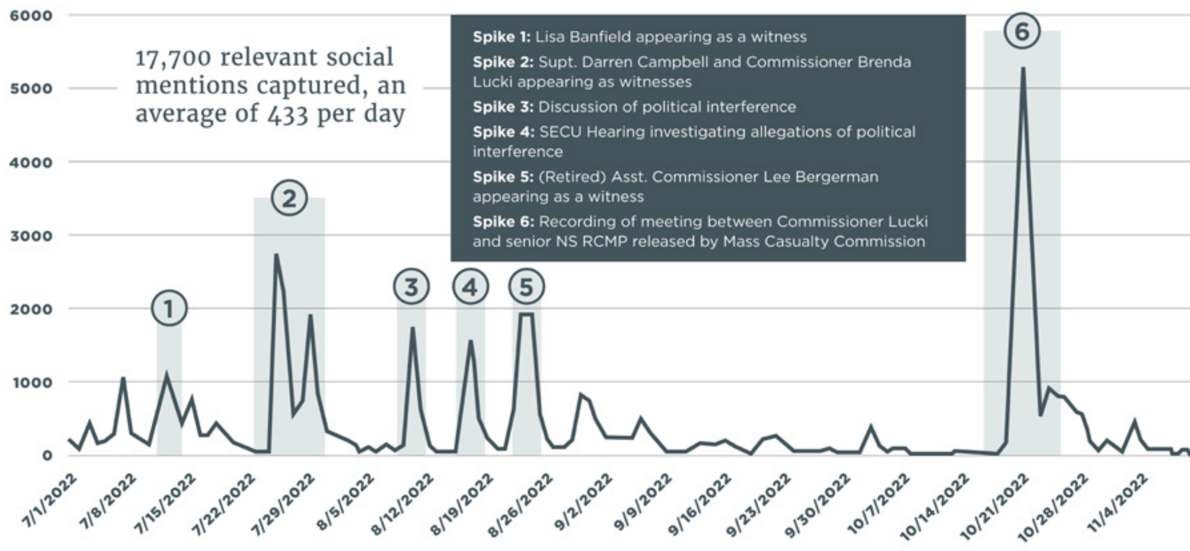
At the outset of the Commission, an assessment of social media conversations and traditional media coverage indicated a general erosion of trust in public institutions following the mass casualty. In the months that followed April 2020, conspiracy theories, misinformation, and allegations of cover-ups began surfacing online. Some people on social media began circulating misinformation surrounding the mass casualty, and there was a notable lack of transparency from the RCMP.

Traditional media focused on emerging details about the attacks, the investigation, and the aftermath of the mass casualty. The legal efforts of families of the deceased were documented, and the efforts of victim-advocacy groups such as the Canadian Red Cross Society, which raised more than $6.2 million for families of the deceased, were highlighted.

True crime–style commentary pieces were also developed following the mass casualty. A podcast titled *13 Hours Inside the Nova Scotia Massacre*, developed by Global News, as well as a documentary by CBC's *The Fifth Estate*, "13 Deadly Hours: The Nova Scotia Mass Shooting," were promoted widely and garnered significant

public attention. Opinion pieces and victim-centric stories about the mass casualty were also common. *Nighttime*, a Nova Scotia–based podcast, began covering the mass casualty regularly and became a gathering place for highly engaged users dedicated to discussing the incident. This podcast traditionally covered Canadian mysteries, true crime, and other events, and ended up dedicating a full show weekly to the mass casualty.

Throughout the work of the Commission, regular monitoring of our social media channels and conversations on social media about the mass casualty and the Commission's work provided insights into key areas of focus for stakeholder groups and the broader public. This monitoring also highlighted some of the persistent challenges related to people's understanding of the Commission's trauma-informed approach as well as issues such as slow document disclosure and our approach to calling and hearing from witnesses. Social media activity and conversations about the mass casualty were frequent. During public proceedings, social media mentions of the Commission and/or the mass casualty averaged from 250 to 450 mentions per day. There were significant spikes driven either by key moments in the course of public proceedings (e.g., hearing from the perpetrator's common law spouse or from senior RCMP leaders) or by external reactions to the Commission's work (e.g., the first day of public proceedings). A sample of social media activity



from July to November 2022 is shown here. All these insights helped the communications team identify opportunities for clarification, further information, or process adjustments.

> **A caution:** Do not lose focus or be distracted by the highly engaged social media users who are not necessarily representative of broader sentiment and should not be mistaken for the public interest or the public voice at large.

The Media

The Commission knew the media would be an important partner in providing accurate information about the mass casualty and the work of the Commission to the public. This is why we worked with the media to facilitate access to and build an understanding of the public inquiry process and our mandate and approach. We also took steps to ensure members of the media were mindful of the potential for wellness impacts arising from the work of covering the Commission and had access to information and resources to support their mental health and well-being.

Although we do not have direct input from members of the media in this Report, we did hear about the impact of the mass casualty on many of them. Several were there during the 13 hours on April 18 and 19. For others, the ongoing reporting took a significant toll, and some developed close relationships with family members of those whose lives were taken. In addition to media briefings, described below, the communications team connected with the media to understand whether they were taking measures to prepare and support their staff. Many members of the province's media were on the ground in the days following the mass casualty and covered it for many months. It was also important to consider the media in the lead-up to sharing information at proceedings. One news director coordinated a webinar on behalf of the Canadian Journalism Forum on Violence and Trauma. The same director had previously hosted similar sessions for journalists covering the mass casualty.

As a joint federal / provincial inquiry with a broad mandate, the Commission established many processes for media during the proceedings. It became clear very early that with such a vast amount of material, document management and the

sharing of relevant and important information would be a challenge. It was therefore important to take a collaborative approach. Working closely with outlets and journalists was a critical component in making processes easier and more accessible for both the media and the public. We heard from the media that it was important for them to have access to documents in advance of their being released during proceedings. As we describe below, a secure file-transfer system was set up to facilitate this access.

Processes for Media

Accreditation

To inform accurate coverage of the Commission's work, and to be transparent, inclusive, and accessible to the public, it was important to ensure the media had an appropriate amount of time and proper access to the information they required. Before proceedings began, we invited members of the media to apply for accreditation to cover the Commission's public proceedings (see application in Annex A). The application for media accreditation was available on our website. The Commission processed and accepted all 91 accreditation applications received (see List of Accredited Media in Annex A).

Accredited media were granted access to designated media areas, including reserved media seating during in-person events; and advance access to the Commission's documents, including our Foundational Documents, before they were made public.

Advance access to documents helped ensure thorough and accurate reporting and supported wellness for members of the media, who are expected by the public to read materials closely – materials that we knew contained difficult content. Providing such access was intended to allow more time to review material in advance of the day it was being addressed or referenced in proceedings. We also wanted to make information as accessible as possible to build confidence and trust in the inquiry process; to support accurate and timely coverage of the Commission's work through transparency and accountability; and to engage with local, provincial, and national media. Despite our efforts, unfortunately the pace of the Commission's work meant that we were not always able to provide access in advance or as far in advance as we would have liked.

Media who chose not to be accredited had access to public seating during in-person events, real-time webcasts of public proceedings, and documents as they were posted on the Commission's website.

Undertakings

To ensure that journalists had the information they needed, the Commission endeavoured to provide exhibits and all documents 24 hours in advance to accredited media who had signed a confidentiality undertaking (sample provided in Annex A). This undertaking was a legal agreement not to share, disseminate, or report on materials before they were shared during the Commission's public proceedings. Undertakings for accredited media limited the possibility of information leaks in advance of the Commission marking these documents as exhibits. The undertaking said users shall not share, copy, or disseminate information from a secure file-transfer system before it is entered as an exhibit. The Commission received 56 signed confidentiality undertakings.

Documents were shared in advance via a secure file-transfer system. Initially, media were cleared to report on the documents shared under the confidentiality undertaking once the documents were posted to the Commission's website. Early on in the proceedings, it became clear that this arrangement was a challenge. Often, a large number of documents caused delays in uploading, and eventually the Commission established a practice of waiting two business days to post to the website in case anyone raised late concerns about documents. This practice was to ensure that the thousands of documents being shared could be carefully reviewed for private or legally privileged information. As a result, media were permitted to report as soon as documents were marked as exhibits in our proceedings, rather than waiting for them to be published online. There were also documents that we, as Commissioners, decided needed to be exhibits but should not be published on the website because of potentially harmful content. For example, the medical examiner's reports were not published but are part of our record. In these cases, we posted summaries in their place. Media received both the original document and the summary so they could confirm the content, but were not permitted to publish more than what was in the summary.

At the beginning of the public proceedings, and occasionally later on as well, we saw instances of the media breaking protocols, particularly publishing content about documents that had not yet been marked as exhibits. In each case, after the

communications team contacted them, the media were accommodating and often appreciative of further explanation. There were no instances where accreditation was revoked, and the communications team worked with the media regularly to help them locate documents, confirm exhibits, or answer questions.

> Briefing media on the document management process and anticipated flow of materials will help journalists plan ahead. Aside from a few inadvertent mistakes that were immediately addressed, media respected the undertakings. We suggest that future inquiries consider a media disclosure process (and education about the process at the outset) as a crucial part of the document management process.

Media Protocols

The Commission created media protocols (see Annex A) that applied during our public proceedings. These protocols, set out on the Commission's website, furthered our commitment to sharing information with members of the media and the public in a timely, transparent, and accessible manner. They addressed topics such as COVID-19 protocols, photography, and video and audio recording.

Before proceedings began, the Commission held a technical briefing with members of the media to review the protocols. This briefing included a walk-through, where members of the media were invited to ask questions about logistics. We updated the media protocols regularly in response to feedback and challenges identified by members of the media.

Media Requests

Throughout our mandate, members of the Commission team responded to media questions or requests in person, by phone, or at our designated media email address (media@masscasualtycommission.ca). Our team tried to accommodate deadlines whenever possible and ultimately help inform, educate, and provide context to the public. Over the course of the Commission, our spokespeople provided written responses to more than 900 email requests.

The communications team worked to build positive and effective relationships with individual journalists and media outlets based on mutual understanding and respect. The team also worked to create realistic expectations on both sides; for example, to ensure that journalists were aware that responses take time and deadlines cannot always be met, but that we would always try to respond in a timely manner to meet their needs.

On-site Media Relations Logistics

Members of the media were on-site daily during public proceedings. The communications team worked to enforce media protocols and regulations such as no filming of people at the proceedings venue without permission, and asking for permission to film and interview through Participant counsel. As requested by outlets, media sprays were coordinated at the start of each week of public proceedings. These media sprays were brief, coordinated windows for media to capture footage of the proceedings space that they could use in their reporting. Ongoing footage (video and stills) was available from shared media resources, including pool cameras for photography and broadcast.

> Working in advance of proceedings with media outlets on potential pool arrangements will determine what is of interest and feasible. Time for planning is required.

Communicating with Media

Accuracy Checks and Corrections

Our communications team regularly monitored media reporting and relevant stories. On finding errors or inaccuracies, the team contacted journalists directly by phone and email if corrections or clarifications were necessary. If reporters did not agree or respond to requests, the team worked to promote corrections and clarifications.

Unfortunately, there were some misunderstandings with the media that we were unable to correct. Each Foundational Document was hyperlinked to connect with its corresponding source materials. Early on in the proceedings, hyperlinks in one document were broken – a technical issue. Although the source materials were there and remained on the website (and available through another source), a Halifax-based print journalist took the broken links to mean that documents had "disappeared" from the website and would not accept the repeated explanations from the Commission or the offer of a call to walk through the website and the document production process. Even more unfortunate was that major national publications picked up this narrative. The document process was complex and, as mentioned, adjustments were made throughout our process. Some documents (though not the documents referenced by the Halifax-based journalist) were removed temporarily and reposted with newly requested redactions or corrections, but nothing ever "disappeared" and was never reposted. This narrative persisted throughout our work and added to distrust of both the Commission and governments.

Spokespeople

We organized an initial webcast briefing with the Commissioners to introduce themselves, the mandate and priorities of the Commission, and the timelines. Although the initial plan was to have the three Commissioners in one location, last-minute COVID-19 restrictions prevented more than five people in one location and meant we had to do the introduction virtually.

Our media protocols noted that, as with most public inquiries, during our mandate we Commissioners would not be doing interviews related to the Commission. Throughout our work, we made public statements, shared announcements, sent regular updates, and were part of public proceedings. The media could quote all this content. However, because we recognized the importance of accessibility and interviews for the media, our spokespeople Barbara McLean (investigations director), Emma Cunliffe (research and policy director), Emily Hill (senior Commission counsel), and Rachel Young (senior Commission counsel and our French-speaking spokesperson) were available as appropriate throughout the Inquiry, including during proceedings. Interviews took place on request. Spokespeople provided interviews to media outlets via phone and Zoom and on live television. We held 10 media briefings over the course of our work to ensure media had the opportunity to ask logistical questions on background and had their questions on the record.

The Commission also facilitated media Q&As with English-speaking and French-speaking spokespeople during the first week of proceedings, and Q&As, interviews, and statements continued on request. Q&As gave media an opportunity to ask questions of Commission spokespeople, who provided statements on the record to be included in coverage.

Media Briefings

We provided regular and timely information sessions or technical briefings before and during public proceedings to share information with the media and to learn what they would find helpful. The purpose of our briefings was to inform, engage, and set expectations with the media as a priority audience to ensure accurate and informed coverage. Briefings provided off-the-record opportunities for the media to help the Commission understand their needs leading up to and during the public proceedings.

Media briefings covered topics such as protocols, issues in the mandate, information about the different phases and logistics of the proceedings, and documents. Media briefings were key to providing this type of access and information in a collaborative way. Most briefings were virtual and not-for-attribution or broadcast, with a 10- to 15-minute period at the end for questions on the record.

It is important to note, again, that **media relations focused on providing information on the work of the Inquiry.** We were making the information available, relaying decisions and updates, but we were not persuading, “pitching,” or attempting to shift perspectives.

An additional note: We had hoped to include journalists in a Phase 2 small group session. We had heard that many families had turned to them for information, and in many cases they were early to the scenes of the mass casualty. We also knew that given the discussion around how people learned about the mass casualty, journalists would have a perspective. We thought this information would be useful for the record. Despite invitations and discussions, invited media outlets turned down the request. The general feedback was that journalists were covering the Inquiry and it was a conflict to participate. We had hoped that journalists no longer covering the Inquiry would consider our request since we thought their insights would be useful. We respect the decision but hope there will be opportunities to discuss what was learned.

Internal Communications

The Commission's broad mandate and ambitious timeline required us, quickly, to bring together a team with diverse expertise in areas including investigations, law, research and policy, wellness and mental health, public engagement and communications, logistics, and administration. The phased approach to our work led to a staggered approach to hiring, with members starting and ending their workdays at different times. Team members were located across Canada, and pandemic public health rules considerably restricted and at times prevented in-person work. As another complication, task-specific teams needed to work in an integrated way.

The difficult and often sensitive nature of the subject matter we dealt with meant we had to be attentive to both the wellness of the Commission team and how members were interacting with Participants, counsel, and other stakeholders, ensuring that we were all continuing to engage in a trauma-informed and respectful way. For all these reasons, we took a thoughtful and consistent approach to internal communications within the Commission team, ensuring that members were informed, equipped, and supported to do their work. We used a range of tactics to communicate with team members, including weekly (and then twice daily during public proceedings) check-ins, virtual and in-person full-team meetings, stakeholder updates, collaboration tools such as Microsoft Teams, regular wellness tips, and dedicated notes from us as Commissioners acknowledging progress and achievements.

The Commission also developed a suite of internal tools to assist team members in communicating with Participants, the public, and others. These tools included a lexicon providing guidance on language use and explanations about Commission terms and writing. The communications team worked closely with Commission counsel and others to produce documents in all subject areas and to develop and fill out templates for presentations delivered to stakeholders and during public proceedings.

> We focused on internal communications to help provide up-to-date information to teams working remotely across Canada, during COVID, and as team members joined throughout the Commission's mandate. We also sought to provide tools and updates to ensure consistency in the information that staff provided.

The Impact of the COVID-19 Pandemic

The COVID-19 pandemic had an immediate and lasting impact on everyone affected directly or indirectly by the mass casualty. Family members, friends, acquaintances, and communities were unable to come together to mourn those who had died or to comfort one another to the extent possible during normal times.

Even before the mass casualty in April 2020, Canadian communities had endured several weeks of disorientation and fear about the threat of this unknown virus, the shutdown of our workplaces and communities, and the profound change in nearly all aspects of our lives. Then, in the wake of the mass casualty, the challenges continued. The pandemic magnified the ongoing trauma experienced by individuals, families, and communities because of the inadequate collective spaces available for the expression of grief, comfort, and support.

The Mass Casualty Commission's work was also affected by the pandemic. Our Orders in Council required us to consider COVID-19 restrictions when we organized in-person meetings or travel and, like everyone else, our planning and progress were hampered by lockdowns, travel restrictions, and isolation requirements. And, of course, within our own team, family members, and vendors, we experienced COVID-19 throughout the two years.

> Inquiries should ensure that staff working remotely have adequate technological, wellness, and other supports.

Throughout our work, we coordinated with Nova Scotia's chief medical officer of health, Dr. Robert Strang, and his office. We took health and safety precautions throughout the course of the Inquiry, including postponing community and witness engagement when necessary. We upheld provincial vaccine requirements for staff attendance at public proceedings and, in some cases, we limited attendance at public proceedings to abide by provincial health guidelines. We proceeded with extreme care for the health of our staff and those with whom the Commission interacted. These measures had a particular impact on our capacity to engage with the communities most affected by the mass casualty. For many of the early

months of our mandate, travel between communities was restricted, as were in-person meetings and gatherings. These restrictions delayed the in-community relationship-building and fact-gathering work with which a Commission of our kind would ideally begin.

COVID-19 challenged our ability to plan our work with firm timelines. We had to remain flexible as meetings and events were restructured or rescheduled because of quarantine restrictions for those entering the province or local surges in cases. Our investigators were ready to carry out witness interviews in the spring of 2021, for example, but because of changing health regulations, they had to be postponed until late summer. For a time, public health orders prevented our staff from travelling through different regions in the province to conduct their investigations. Our inability to firmly control the timing of our processes complicated our work, making it difficult to plan next steps with certainty.

Commission staff navigated COVID-19 challenges in the lead-up to and throughout public proceedings. Our team worked closely with partners at the venues, including translation services, security, and catering, and with Nova Scotia Public Health to understand how changes to provincial gathering limits would affect public attendance at proceedings and the size of venue we might need to accommodate physical distancing requirements. Despite not knowing what the public health guidelines might require, we did have to make advance bookings with venues that covered any eventuality. We also worked with the media to ensure coverage of proceedings, and we were flexible and always prepared to proceed virtually if necessary.

We were able to ensure that family members of the deceased could attend the start of proceedings at the Halifax Convention Centre but, because of public health guidelines in effect at the time, members of the general public were not able to be there. Soon after, however, the Province eased gathering limits and we were able to welcome the public. Regardless of COVID-19 in-person gathering restrictions, all members of the public could watch the proceedings on the Commission webcast at any time during our public proceedings and always had access on our website to the transcripts and exhibits.

At the outset of public proceedings, proof of COVID-19 vaccination was required for anyone taking part in person at the Halifax Convention Centre or the community viewing site in Truro. We did not copy or retain anyone's proof of vaccination but did record that it had been provided so that individuals were not required to produce proof every time they attended. Masks and proof of vaccination requirements remained in place as outlined by Nova Scotia's reopening plan.

The Commission continued to monitor the guidelines set by the Province and provided updates when requirements changed. By the second week of proceedings, the Province's COVID-19 reopening plan stated that people no longer required proof of full vaccination to attend non-essential events.

The pandemic challenged our efforts to work collaboratively with our many Participants. We could not hold in-person community meetings in affected communities early in our mandate as a result of the public health restrictions on travel and occupancy / distancing in meeting rooms. The entire team was hampered by the inability to build rapport with those most affected in the absence of opportunities to meet one another. Although we intended the Commission to operate on a non-adversarial basis with Participant counsel, the reduced ability for counsel to meet in person early in the mandate likely made the shift in mindset from the traditional adversarial model even more time-consuming and difficult to achieve. We believe that many aspects of the Inquiry would have been different but for the unprecedented situation caused by the COVID-19 pandemic.

Interim Report

The Interim Report was a significant effort on the part of many people. With a mandate as condensed as ours and the sensitive nature of the content, it was a challenging undertaking but required by our Orders in Council. The delays we experienced with disclosure and with opening public proceedings created added complexity because the Interim Report had to be completed and sent for translation by early March 2022.

We needed to set expectations with our stakeholders and with an engaged public that the Interim Report would not include facts of what happened or recommendations. Instead, in the Interim Report we shared how the Commission was doing its work, on behalf of Canadians, to meet the requirements of the mandate outlined in the Orders in Council, including the work to date, and what to expect as we fulfilled our mandate. The Interim Report's content included the important questions that would be examined in relation to key topics, among them critical incident response, firearms, police paraphernalia, intimate partner violence, rural communities, and post-event support.

The Interim Report was a noteworthy effort by many Commission team members to not only produce a report with proceedings underway but also to coordinate with both levels of government in advance to make the Interim Report available in accordance with the requirements outlined in our mandate.

> In a relatively brief mandate, the requirement to produce an interim report diverts time and resources away from the substantive work of the commission. Requiring commissions to provide stakeholders and the public with regular updates about its activities and progress is a more effective way of promoting accountability.

CHAPTER 4

Our Work: Three Phases

CHAPTER 4 Our Work: Three Phases

At a general level, public inquiries have the following tasks:

- conducting investigations;
- gathering evidence and information, including by seeking all relevant documents, interviewing witnesses, commissioning research and policy studies, and engaging in consultations;
- providing individuals and groups that have a substantial and direct specific interest in the subject matter with an opportunity to participate in the inquiry processes;
- creating a public record of the relevant evidence and information;
- inviting Participants and members of the public to comment on and add to this record;
- reviewing and synthesizing evidence and information;
- considering evidence and information and determining relevant facts;
- reviewing information, research, and submissions by Participants and members of the public about potential areas for reform and specific recommendations;
- formulating recommendations relevant to the mandate; and
- preparing a final report.

Though public inquiries share these general steps, they each develop a unique process suited to their mandate. Commissioners make important choices about the way they will go about their work, and they have considerable latitude in designing their processes.

Our objective was to find out what happened, and how and why it happened, so we could distill the lessons learned from the mass casualty and make recommendations to help ensure the safety of our communities in the future. Throughout our mandate,

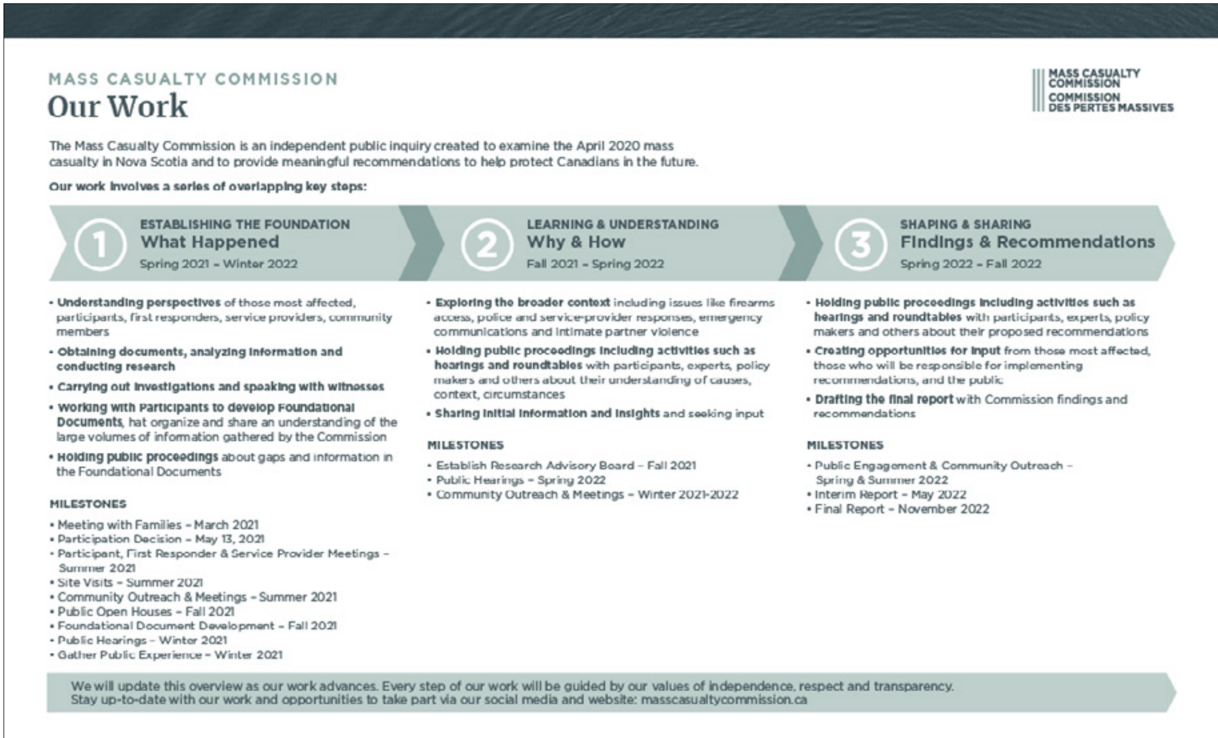
we endeavoured to create conditions that would encourage those who had a direct and substantial interest or relevant information to engage with our work and participate in our efforts to achieve these goals. To that end, we adopted an inclusive, restorative approach rather than a divisive, adversarial one, in the hope that those entrusted with the effectiveness of our institutions and systems will, going forward, continue to operate in this same spirit of individual and collective responsibility.

> The advantage of a public inquiry's inquisitorial process is that it does not focus on seeking to lay blame on individuals at the expense of a careful scrutiny of institutional accountability. If we had restricted our investigations to pointing fingers at alleged human errors, we could easily have overlooked broader issues relating to the causes, context, and circumstances that explain how and why the errors occurred. Processes that focus on individuals could offer scapegoats for institutions and systems that were ultimately accountable for the response needed to the mass casualty. Our lens, however, had to be systematic and expansive enough to look at individual and collective actions, decisions, and other behaviours and, in addition, to examine the cultures, policies, practices, and institutional structures and systems giving rise to them and shaping them. We could not go back in time to change what happened on April 18 and 19, 2020, but we could and had to look back at what happened in order to look forward and make evidence-based recommendations to help prevent and respond to similar incidents in the future.

We developed a phased approach to our work that systematically matched the three functions assigned to us in our mandate:

- Phase 1: establishing the foundation (what happened);
- Phase 2: learning and understanding (how and why it happened); and
- Phase 3: shaping and sharing (the significance of what happened and how we must respond).

The three phases were designed to ensure that the interests of those most affected were addressed early, and at the core, to inform the rest of our work. Utmost in our minds when designing the phases were the people affected by this work. How could they best participate, share, and disclose fully? Given the lack of information about what happened, we prioritized clarifying facts first. In Phase 1, the



Commission focused on establishing what happened leading up to, during, and after the mass casualty. This work is described in the section below: "Phase 1 – Building the Core Evidentiary Foundation." One of our priorities was to share this information with the public as we learned it, rather than waiting until the Final Report. This approach served two purposes. First, at the start of our mandate the public had known little about what happened on April 18 and 19, 2020. There was widespread public frustration and a loss of trust in the RCMP owing to their release of limited and at times inaccurate information in their communications about the mass casualty and their responses to it. Second, by beginning with what happened, we hoped to answer the public's pressing questions about the mass casualty, and to encourage public engagement with the Commission's work of trying to understand not only what happened, but how and why it happened.

In Phase 2, as we describe below in "Examining Causes, Context, and Circumstances," the Commission sought answers to questions about how and why the mass casualty occurred. Our focus was on exploring issues surrounding the mass casualty, including those set out in our Orders in Council such as access to firearms, responses by the police and service providers, emergency communications, and intimate partner violence.

In Phase 3, as set out in "Shaping and Sharing," we looked forward and focused on how best to make a difference in the future. As we formulated our recommendations, we consulted with those most affected, Participants, members of the public, and other diverse communities and groups and learned from the perspectives they shared with us.

From the beginning, we knew we would have to be flexible in our approach to these three phases and that our work on them would constantly overlap. Overall, we found the division to be helpful in organizing our efforts, sequencing, priority setting, and facilitating how we communicated with our own staff and the public. In essence, in Phase 1 we focused on ascertaining the facts; in Phase 2 on understanding the facts in the broader context; and in Phase 3 on distilling what lessons could be learned from that understanding.

While we were developing our overall design of the phases, we also began to develop thematic approaches to refining the many issues that arose from the mass casualty. We organized the Commission's work around three main themes or pillars: policing, community, and violence.

Early on it was clear that the breadth and complexity of our mandate, and the short timelines for delivering our Final Report, required an inclusive approach. We needed to be efficient and effective in our work, in order to avoid duplication and errant tasks. In short, we had to be more than the sum of all our parts. To meet this objective, we set up integrated work teams consisting of members of the investigations, research and policy, and Commission counsel teams to assist us in identifying all the relevant issues and to gather and analyze information and evidence about each of them. We called these integrated work teams "pods."

The immediate advantage of the pod approach was that it quickly created networks within the Commission's overall structure and tapped into team members' varied expertise that, otherwise, could have remained siloed. This interdisciplinary approach was particularly helpful in addressing the disjointed and sluggish disclosure of the documents we requested, in identifying our need for new information and the potential sources for that information, and in managing witnesses, community outreach, and the overall planning of our work.

Because the Commission did not exist before its Orders in Council were issued, many team members became tasked with developing the Commission's processes while also advancing the work assigned to the pods in their particular area of expertise. As an unintended benefit, this dual role enabled colleagues in the pods to keep their work moving when key team members were tasked with

tight timelines for other responsibilities. Their professional dedication meant that, despite constant pressures and their location in different time zones, they were able to manage this integrated work schedule, though not without it taking a personal toll on them over the two-plus years of the Inquiry mandate.

> Adopting an interdisciplinary approach allows a commission to work cohesively on complex matters. This approach requires adaptability on the part of team members. It can take time to build trust and mutual understanding at the outset, but it creates a stronger foundation for a commission to make evidence-based findings and recommendations.

Developing the Framework

The Research Advisory Board

We established a Research Advisory Board to advise us on the design and implementation of our research and policy process. Its members, listed below and with biographies in Appendix G, were eminent academics with expertise in community processes that encourage a meaningful dialogue in consultation and policy development. Their collective experience spanned areas important to our work, including criminology, sociology, law, and psychology. Recognizing the importance of local culture and community, we appointed several Nova Scotians as well as others whose expertise complemented our mandate to address the needs of different groups in society. We consulted with the board at key points in our work, and members of our research and policy team kept in ongoing contact with individual board members as their work required. The board provided us with valuable advice on key research questions, expert reports, policy roundtables, and the process of formulating recommendations.

Research Advisory Board members:

Professor Judith Andersen, University of Toronto

Professor Diane Crocker, Saint Mary's University

Professor Ian Loader, University of Oxford

Professor Jane McMillan, St. Francis Xavier University

Professor Naiomi Metallic, Schulich School of Law, Dalhousie University

Professor Emeritus Akwasi Owusu-Bempah, University of Toronto

Peter Russell, Professor Emeritus, University of Toronto

The Honourable Lynn Smith, OC, KC, Honorary Professor, Peter A. Allard School of Law, University of British Columbia

An inquiry can greatly benefit from the expertise, contacts, and advice of a small group of subject matter experts throughout its process.

Environmental Scans

Our Orders in Council required us to consider the findings of relevant previous examinations and investigations. Early on, when the research and policy team initiated an environmental scan of relevant existing reports, we provided two framing concepts to guide their work:

- What areas unique to this mass casualty might give rise to new recommendations?
- What areas that arose in this mass casualty have been the subject of past inquiry or review recommendations? If those recommendations were not implemented, what were the barriers to implementation?

The Mass Casualty Commission's environmental scan, a compilation and analysis of the findings and recommendations contained in past public inquiry reports and institutional reviews, provided us with a solid understanding of problems previously identified and paths already proposed by others.

Environmental Scan of Recommendations in Previous Canadian Reviews

The environmental scan brought together findings and recommendations from previous Canadian and provincial reviews about issues identified in our mandate. Reports within the scope of this tracking included:

- commissions of inquiry;
- government standing committees;
- law reform commissions;
- government-commissioned evaluations and reviews;
- the RCMP's Civilian Review and Complaints Commission; and
- coroners' inquests.

Reports from public interest groups or think tanks were not included, nor were reviews that made no recommendations. The research and policy team reviewed other types of reports and research as needed to fill gaps in our evidentiary record.

This compilation and analysis provided us with a solid understanding of the problems that had been identified previously and the possible solutions they had proposed. They enabled us to build on past recommendations and to move forward with our own. We also tried to identify which recommendations had been implemented and, where possible, to find any evaluations of their impact. Equally important, we documented instances in which institutions had been given opportunities to change but had not fully implemented the recommendations. Learning about past obstacles and challenges assisted us in designing recommendations capable of addressing common roadblocks to change. Our public proceedings and conversations with individuals and groups through a range of Phase 2 and Phase 3 activities gave us a better understanding of these past experiences.

The environmental scan included an analysis of 71 public inquiry reports and institutional reviews that were grouped according to topics relevant to the Commission's mandate and approach:

- police oversight, training, preparation, and culture;
- communications among and within law enforcement agencies;
- communications with community (contemporaneous response to victims and the community; emergency alerts);

- active shooter events; and
- gender-based and intimate partner violence.

Not all mass casualty incidents lead to reviews or recommendations. For example, a coroner's inquest into the murder of 14 women at the École Polytechnique in Montreal on December 6, 1989, along with the death of the perpetrator, made findings of fact and raised questions regarding the response to the mass casualty but included no recommendations.[1] Moreover, for some issues within our mandate, we were unable to identify any past official reviews.

Within each topic area, the scan began with Nova Scotia reviews and then looked at national reviews and select reviews from other provinces. It summarized the background and mandate of each review and listed the issues on which recommendations were made. Recommendations with relevance to our mandate were included. Whenever possible, the scan included information on the implementation of recommendations.

We shared the draft environmental scan and the reports on which the scan was based with Participants on May 25, 2022. In return, they gave us useful input, such as alerting us to some additional reports. We then finalized the scan and shared it with the public in Phase 3. The environmental scan is also reproduced in Annex B: Reports.

> The environmental scan provided us with a strong sense of the history of reform efforts in several key areas of our mandate. It also allowed us to assess patterns in the implementation of recommendations and to identify some common obstacles. Knowing what recommendations have been made in the past, and with what success, was an important part of our work to generate recommendations about the issues within our mandate. We hope that publication of this scan will serve other commissions, policy-makers, organizations, and individuals who are interested in the history of Canadian policy in areas within our mandate.

International Scan

As part of our mandate to make findings and recommendations relating to "the responses of police, including the Royal Canadian Mounted Police (RCMP) and municipal police forces" and to assess "the steps taken to inform, support and engage victims, families and affected citizens," we also conducted a scan of reports and recommendations from international jurisdictions that have responded to similar mass casualties.

A comparison of the expectations and standards in public safety between Canada and our international peers offers a useful perspective. The scan focused on countries that have experienced similar mass casualties and have a similar legal and constitutional structure to our own. We identified reports that were significant not only because they investigated mass casualties that were similar to the one in Nova Scotia but also because they set relevant standards, were comprehensive, or offered solutions and recommendations pertinent to our mandate.

In total, we summarized the reports from six international mass casualties:

- Christchurch masjidain terrorist attack, 2019 (New Zealand);
- Orlando Pulse nightclub shooting, 2016 (United States);
- Oslo and Utøya Island mass casualty, 2011 (Norway);
- Cumbria mass shooting, 2010 (United Kingdom);
- Dunblane primary school mass shooting, 1996 (United Kingdom); and
- Hungerford mass shooting, 1987 (United Kingdom).

In addition, although the report relating to the mass shooting in Plymouth, England, in 2021 has yet to be released, we provide an overview of that incident in the introduction to the United Kingdom summaries.

The Commission also shared the international report summaries and their source documents with the Participants. We have also reproduced them in Annex B: Reports. The coroner's report and the New South Wales review stemming from the Lindt Café Siege in 2014 in Australia are also pertinent to our work. These reports are discussed in an expert report prepared for the Commission by Dr. Jude McCulloch and Dr. JaneMaree Maher.[2]

We found that agencies in the United States had generated many reports about mass casualty events, and it was not possible for us to summarize them all. Instead, after a preliminary review, we focused attention on the National Policing Institute's

review of the Orlando Pulse nightclub shooting in 2016. This report is the most comprehensive of the institute's recent reports on mass shootings in that it articulates the fundamental principles of a successful critical incident response. In addition, it identifies effective aspects of the Orlando Police Department response, allowing it to serve as a model in this regard.

An important point that emerges from the international scan is that Canada is not alone in having to face the reality of mass casualty incidents and the significant threat these incidents pose to public safety. These reports provide Canada with the opportunity to measure its standards and levels of preparation against those in other countries and to benefit from the recommendations and solutions emerging from comparable countries facing similar concerns.

> Producing an environmental scan of past reports and recommendations allows a commission to focus its efforts on addressing gaps in past reviews, and on evaluating the effectiveness of past recommendations. An environmental scan can also provide important information about patterns in institutional responses.

Commissioning Expert and Technical Reports

We commissioned 23 expert and technical reports focused on the issues set out in Phase 2 and Phase 3. They built on issues that emerged from our Phase 1 work, the environmental scan, and the advice of the Research Advisory Board and focused on public policy, academic research, and lessons learned from previous mass casualties.

> **Expert and technical reports:** These concise documents, prepared by independent report writers, helped us to better understand key issues in our mandate.

The technical reports provided an objective and factual account of some of the key government and policy structures relevant to our mandate. In selecting writers for technical reports, the Commission sought subject matter experts with relevant experience who were at arm's length from the Participants. We commissioned

two such reports: the first, on the structure of policing in Nova Scotia by Barry MacKnight, a former president of New Brunswick chiefs of police and vice-president of the Canadian Association of Chiefs of Police, was presented early in the Phase 1 public proceedings.[3] The second technical report, by Chris Davis, Cheryl McNeil, and Peter Gamble, "Communications Interoperability and the Alert Ready System," focused on emergency alerting and communications during critical incidents.[4]

The expert reports, described in more detail in the Phase 2 section below, provided the Commission and the Participants with expert opinion evidence about matters relevant to our mandate – in particular, the themes of policing, community, and violence. They analyze matters such as critical incident decision-making, police culture, policy-making for rural communities, best practices for forensic psychology, and ways to support individuals and communities following a mass casualty. In selecting writers for these reports, the Commission, in consultation with the Participants, relied on Canadian legal criteria for expert witnesses – independence, specialist knowledge, and the suitability and reliability of research methods. The selection of topics for expert reports reflected the issues set out within our mandate and followed the themes of policing, community, and violence. The Commission team consulted with Participants on potential topics and possible authors when deciding what expert reports should be commissioned. These reports were shared with Participants first to allow them to prepare for the Commission's public proceedings and were then posted on the Commission website. All the completed reports can be found in Annex B: Reports. Many of the authors were invited to participate in public proceedings as witnesses, as members of expert panels, and/or in roundtable discussions.

> Commissioning concise reports that directly address the questions within a commission's mandate is a more effective strategy than obtaining longer and more general reports.

Preparing Legislative Briefs and Policy Documents

The Commission shared 11 policy documents throughout our Phase 2 proceedings. These documents, prepared by Commission counsel and the research and policy team, included material gathered by the Commission and shared throughout the proceedings, such as summaries of key information about legislation or policies relating to areas in the Commission's mandate. Four of the policy documents we produced were legislative briefs on the topics of police impersonation and paraphernalia, firearms, Nova Scotia's Alert Ready system, and the perpetrator's violence and financial dealings. Two of the other documents related to the Canada Border Services Agency's firearms policy and to policies on intimate partner violence, family violence, and gender-based violence. The last four documents were compilations of RCMP policies, both national and specific to Nova Scotia's H Division (see Appendix H for a complete list).

Phase 1: Building the Core Evidentiary Foundation

Early in its work, the Commission focused on building the factual foundation for both the Phase 1 inquiry into what happened on April 18 and 19, 2020, and the Phase 2 examination of the causes, context, and circumstances that helped to explain the how and why of what happened. Our initial approach was threefold:

- to carry out extensive investigation and information gathering;
- to review and analyze this mass of information and distill it in draft Foundational Documents that provide an accessible account of the mass casualty and related issues; and
- to consult with Participants on the drafts and, based on their input, prepare revised Foundational Documents.

This extensive foundation-building work was carried out collaboratively by our Commission counsel, investigations, and research and policy teams.

Investigation, Information Gathering, and Information Sharing

To begin, the Commission took steps to obtain the information necessary to carry out its mandate. We followed three interrelated avenues in our investigation and information-gathering work: document production, management, and disclosure; investigations; and witness interviews.

Document Production, Management, and Disclosure

In any public inquiry, there are three fundamental and related tasks. The first, document production, is our obligation to obtain all the relevant documents from all the people or institutions that are in possession of them. The second, document management, is to organize and categorize these documents, combing through them line by line and identifying privacy and other issues that need to be protected from public disclosure. Commission staff often consulted on specific issues with the families and those most affected. The third, disclosure, is to release all documents not identified as protected, first to the Participants and then to the public. We faced considerable challenges with each of these tasks.

> Issuing subpoenas should occur as soon as practicable. Inquiries should also ensure early procurement of a document management platform.

Document Production

All public inquiries have the power to require document production – a legal process, by subpoena, where individuals, organizations, and institutions are compelled to share information.[5] The governing statutes confirm, and our Orders in Council acknowledge, that we could compel anything we “deem requisite to the full investigation of the matters into which they are appointed to examine.”[6] Through our document production process, the Commission could subpoena documents and information from various sources. In the context of our work, a subpoena is a legal document that orders a named individual, institution, or organization to produce

documents and other types of information. Since this Commission did not have search warrant powers, it could not seize documents in a particular format.

The Commission began seeking document production from all relevant parties soon after we established our offices and hired Commission counsel and a document management team. Commission counsel initiated discussions with the Attorneys General of Canada (representing the RCMP) and Nova Scotia, and other entities that held information to advance our mandate in order to understand where all the requisite documents were held. We then issued general subpoenas to the Attorneys General of Canada and Nova Scotia on March 18 and 25, 2021, respectively. Counsel for those entities then gathered the documents and reviewed them for privilege prior to producing them to the Commission. By the end of our mandate, the Commission had issued more than one hundred subpoenas that produced more than 80,000 documents, including investigative files, emails, notes from first responders, transcripts of police radio communications, visuals such as photographs, and over one thousand audio and video files. The obligation to produce documents was ongoing during our mandate, and the Commission continued to seek and receive requisite documents throughout our public proceedings.

Document production is a time-consuming part of any legal process, especially public inquiries with their broad terms of reference. The Commission required a wide range of documents: both those related to the mass casualty itself, which was the focus of Phase 1, and those related to the broader contextual issues required to build the evidentiary foundation for Phase 2. Our subpoenas included institutional records and various types of policies and training manuals. Compelling a party to produce all requisite documents is rarely straightforward and can require considerable effort to understand the form in which records exist and how best to ensure that the party provides the information that is actually being sought. Pursuant to the governing statutes, we had the authority to compel written evidence.[7] As detailed below, this is one of the methods we used in our attempt to secure the required information from the RCMP.

The Commission experienced some delays in the document production process caused by a number of factors beyond our control, including that, for several months, government departments were operating remotely because of health orders related to COVID-19 and the Attorney General of Canada was transitioning to a new document management system. However, the most significant delay was due to the pace and manner of disclosure by the RCMP and the Attorney General of Canada. We note that past inquiries and reviews also had this experience. Two

examples are the Independent Civilian Review into Matters Relating to the G20 Summit (Toronto Police Services Board, 2012) and the National Inquiry into Missing and Murdered Indigenous Women and Girls (2019).

The Independent Civilian Review into Matters Relating to the G20 Summit requested access to documents pertaining to the G20 Summit from the Toronto Police Service, the Toronto Police Services Board, and the RCMP. The Service and the Board were responsive and co-operative. However, despite repeated requests, the RCMP did not agree to produce documents to the review until nine months after the request. The final report noted that while the RCMP ultimately provided co-operation "to the Review in the production of documents, the stage at which it occurred caused delay in the ultimate completion of this Report."[8]

The National Inquiry into Missing and Murdered Indigenous Women and Girls examined the systemic causes of all forms of violence against Indigenous women and girls in Canada, as well as the institutional policies and practices implemented in response to this violence. In addition to hearing testimony, the inquiry engaged in a review of police files from across the country relating to missing and murdered Indigenous women, girls, and 2SLGBTQQIA people. This was referred to as the Forensic Document Review Project (FDRP) and was designed to identify and make recommendations relating to systemic problems, barriers, and weaknesses in the investigations of missing person reports, suspicious or implausible deaths, and acts of violence against Indigenous women, girls, and 2SLGBTQQIA people. The report explained that the number of police files it was able to subpoena and review was limited, given the length of the inquiry's mandate period. Municipal and regional police forces generally co-operated with the FDRP, devoting extra resources and people to the task of complying with subpoenas in a timely way. However, the report noted significant issues with the RCMP.

By contrast, the RCMP demonstrated reluctance to provide the FDRP with the information requested. The degree to which the RCMP, represented by the Attorney General of Canada, resisted disclosure of the files sought by the FDRP created a challenge to the FDRP's ability to obtain and review the necessary documents. Many of the files received contained redactions that rendered some documents unintelligible, affecting the analysis. This problem is particularly significant because the RCMP is the national police force responsible for policing approximately 40 percent of the Indigenous population and 39 percent of unsolved cases reviewed by the FDRP.[9]

There are a few reasons for the challenges we encountered in this Inquiry with RCMP / Attorney General of Canada disclosure, some of which were on us. For example, owing to our integrated approach with regard to the fact-finding and policy aspects of our mandate, different Commission teams had different interests in disclosure, but the conduit for dialogue with federal Department of Justice lawyers was via Commission counsel. Internal communications between teams did not always produce consistent interpretation of relevancy to the mandate and prioritization of requests. As our understanding of the file evolved, our requests and priorities necessarily changed as well. Although an inquiry context is unique with regard to the possibility of access between counsel in a collaborative way, this kind of co-operation requires a robust process internally at the inquiry to ensure a consistent message is provided to those from whom it seeks disclosure. This effort was further complicated by the fact that, with a broad, time-limited mandate, we had to retain and manage a large Commission team.

The Commission did not have the power to require parties to provide documents organized in a specific manner or in a specific electronic format. For example, it could not, as in a police search warrant, require parties to produce documents in one delivery or to produce intact original electronic documents. This limitation made a significant difference in the timing of document production for key documents such as the H-Strong investigative file and the RCMP Policy Manual.

To meet our mandate, the Commission needed to understand fully the legislative, regulatory, and policy contexts for policing and other services involved in emergency response in Nova Scotia. Policing institutions produced a vast array of documents, including institutional decision-making structures, policies and programs, and training manuals and programs. Furthermore, we often had to tax our limited resources to distill the required information from the material we did receive under severe time constraints. By late 2021, the RCMP had failed to provide a considerable amount of material that we had expected to receive in response to our subpoenas. Consequently, we issued a request for written evidence, under subpoena, to try to elicit the needed material. In the subpoena we required the RCMP to produce evidence in writing. The evidence requested by this means included descriptive information about the RCMP's human resources, operations, policies, governance, equipment, training, and interoperability with other agencies.

Given the complexity of the RCMP structure and the large number of relevant policies and programs, the Commission directed the RCMP to prepare written evidence reports of how its structure, programs, policies, and training were designed

to work individually and how these elements interconnect.[10] In response to this subpoena, we received more documents and tables detailing the production of documents, but many challenges persisted.

The late disclosure of various RCMP members' and officers' notes also hampered our ability to gain a complete understanding of the RCMP's critical incident response. In our decision of March 9, 2022 (Appendix I-1), we confirmed that the Commission would be calling a number of senior RCMP witnesses to testify during upcoming public proceedings. Therefore, the RCMP and the Attorney General of Canada were aware by no later than March 9, 2022, that they should be producing documents relevant to at least those senior RCMP members. In our previous subpoenas, dated March 25, 2021, and June 15, 2021, we required the production of all documents requisite to our mandate, including police notes and reports as well as relevant emails and other correspondence. In some cases, though, we did not receive relevant documents, including notes, until after a member's scheduled interview and even, in some instances, until after the witness had testified, despite our request that documents be provided in advance. In one instance, the Attorney General of Canada had omitted four pages of Supt. Darren Campbell's notes from the production without advising the Commission it had done so. Later, the notes with the four pages added back to them were disclosed but without indication that they had been added. It was only after careful review and comparison of the second production of the notes that Commission team members discovered there had been missing pages in the first disclosed version. The Commission sought an explanation from the Attorney General of Canada and was advised that the pages had been held back as privileged. By reply letter to the Commission, the Attorney General of Canada "acknowledge[d] that the Commission was not advised that these pages were being reviewed for privilege. DOJ counsel should have done so."[11]

While we acknowledge that we share some responsibility for some of the challenges, there were significant issues with the form, manner, and pace of disclosure from the Attorney General of Canada on behalf of the RCMP, despite the RCMP having established an Issues Management Team ostensibly to manage its response to the Inquiry.

Document Management

The Attorney General of Canada produced materials on a rolling basis, beginning March 18, 2021, and continuing until October 4, 2022, once the Commission advised

it that to meet the timelines set out in our mandate, we could no longer accept any further document production after this date. The manner in which materials were produced created an enormous task of review and analysis for the Commission and Participants. Many of the RCMP documents had meaningless titles and little contextual information and required a detailed review by the document management and analysis team. The poorly organized state of the materials received from the Attorney General of Canada on behalf of the RCMP was a source of frustration for both Commission staff and the Participants and caused significant delays. The form of document production also created considerable and costly additional work as staff analyzed what the Commission had received.

Legal Privilege Claims

Some of the documents the Commission received were subject to claims of privilege. Rule 19 of the Commission's Rules of Practice and Procedure describes the process for addressing such claims:

> Where a Participant objects to the production of any document on the grounds of privilege, a true copy of the document will be produced in an unedited form to Commission Counsel who will review and determine the validity of the privilege claim. In the event the Participant claiming privilege disagrees with Commission Counsel's determination, the Commissioners, on application, may inspect the impugned document(s) and make a ruling.[12]

This process created a tension, particularly with the Attorney General of Canada. To meet the challenging deadline set out in its Orders in Council, the Commission required prompt disclosure, particularly from the main document holder, the RCMP as represented by the Attorney General of Canada. Yet, the Attorney General required sufficient time to ensure it did not inadvertently disclose privileged documents. To address this issue, the Commission entered into a "claw back" agreement with the Attorney General. Essentially it stipulated that in order to encourage prompt disclosure, the Commission agreed that the Attorney General could demand a "claw back" of any privileged documents that may have been missed and inadvertently disclosed following its initial review. Once a document was so identified, the Commission would promptly return it and undo or "claw back" any distribution that had already taken place. In return, the Attorney General

agreed "that no allegation of tainting or bias will be made against the Commission on the basis of it having received or reviewed inadvertent production." In the event of a disagreement over whether any document identified for claw back was actually privileged, the process set out in Rule 19 would be invoked.

This arrangement unfortunately met with two unintended challenges. First, there was no time limit on when the Attorney General could demand a claw back. On at least one occasion, the Attorney General required us to claw back a document after it had been posted on our website. It had to be taken down immediately, redacted to remove the privileged aspects and then reposted. This led to a media backlash, alleging that we were not being transparent as a Commission. Secondly, the Attorney General had on occasion sought to claw back information in a particular document, only to have us later discover that this same information was contained in other documents that had also been disclosed and relied upon by the Attorney General (for example, as responsive to a request for written evidence). This arrangement caused enormous challenges for our Commission counsel and document management teams.

> In light of these lessons learned, when entering into similar arrangements, we suggest that future commissions require (a) the document holder to promptly complete its second review and to advise the commission of any required claw backs at the earliest opportunity; and (b) that all documents containing the privileged information be identified in the original claw back demand.

In some cases, the RCMP through its counsel, the Attorney General of Canada, advised Commission counsel of a document it would not produce, or redacted other documents, claiming the document was not requisite to our mandate. For example, the Independent Officer Review into the 2017 complaints made by Susan Olive Butlin about Ernie "Junior" Duggan[13] was not provided in response to the general subpoena to the RCMP. After it was specifically requested by the Commission, the report was provided with the names of the RCMP members at the Bible Hill detachment who had responded to the related calls redacted as "irrelevant." Ms. Butlin had made a sexual assault complaint against Mr. Duggan to the RCMP and was later murdered by him, as described in Volume 5, Policing. The case involved gender-based violence, a murder in a rural community in Colchester County, and several of the RCMP members who were first responders in the mass casualty (Cst. Stuart Beselt, Cst. Rodney MacDonald) and/or had contact with the

perpetrator (Cst. Gregory (Greg) Wiley). In our view, the involvement of some of the same members was certainly requisite to the Inquiry's work. Another example is the Independent Officer Review regarding the shooting of Peter DeGroot,[14] a man fatally shot by police in Slocan, British Columbia, after an exchange of gunfire prompted a multi-day large-scale deployment in search of him. We subpoenaed this report on August 16, 2021. More than a year later, on September 22, 2022, the Attorney General of Canada advised that the report was not being produced because the file was subject to an upcoming inquest, objecting to its disclosure on public interest grounds. The Commission challenged this assertion of privilege. On October 2, 2022, the Attorney General of Canada wrote with a "Correction" in which it said the privilege claim was "an error"; privilege was not claimed over the document, and it would be disclosed as soon as practicable.

As for claims of privilege, as noted above regarding C/Supt. Campbell's withheld notes, because we learned that the Attorney General had not notified us of a redaction made, we became concerned that we did not know what else might have been withheld without notice to us. In other instances, the Attorney General of Canada invoked privilege in contexts that did not appear to create such a privilege. In most cases, these issues were resolved through discussion between counsel for the RCMP and Commission counsel. On one occasion, concerning the Summary Report re: Wellness Assessment,[15] such resolution was not possible and Commission counsel made a written application for a ruling that certain redactions applied by the Attorney General of Canada were not justified. Participants also made submissions and, after their review, we directed that redactions be lifted because they were not justified by the Wigmore privilege.[16]

LITIGATION PRIVILEGE

The Attorney General of Canada on behalf of the RCMP also relied on what is known as "litigation privilege" to justify withholding certain documents. This privilege protects parties immersed in the adversarial system from disclosing documents prepared primarily to protect their interests in litigation that is either anticipated, contemplated, or ongoing.[17] It is very much aligned to the adversarial process. Here the Attorney General of Canada on behalf of the RCMP maintained that litigation privilege applied to documents prepared in contemplation of this Inquiry. In other words, it withheld certain documents that it asserted were created for the dominant purpose of representing its interests before the Inquiry. This begs a fundamental question: does litigation privilege attach to non-adversarial public inquiries such as ours?

We acknowledge that this issue represents an unsettled legal question in Canada and an important one. It arose late in our process, and we did not have the opportunity to resolve it in the context of a specific claim of litigation privilege. We did turn our minds to this issue and want to comment on it for the benefit of future commissioners and future participants in public inquiries. **In our view, litigation privilege is inconsistent with a non-adversarial inquisitorial process.** We are persuaded by and endorse the approach of the Manitoba Court of Appeal in *Hudson Bay Mining and Smelting Co v Cummings* (2006).[18] There, Justice Freda M. Steel, for the court, considered this issue in a context similar to ours; namely, an inquest under the Manitoba *Fatalities Inquiries Act*.[19] She began with the application and purpose of litigation privilege, emphasizing its alignment with the adversarial process:

> 30 In Robert W. Hubbard, Susan Magotiaux & Suzanne M. Duncan, *The Law of Privilege in Canada*, looseleaf (Toronto: Canada Law Book, 2006), the authors summarize the litigation or work product privilege rule as follows (at paras. 12.10, 12.20):
>
>> Litigation privilege, also called work product privilege, applies to communications between a lawyer and third parties or a client and third parties, or to communications generated by the lawyer or client for the dominant purpose of litigation when litigation is contemplated, anticipated or ongoing. Generally, it is information that counsel or persons under counsel's direction have prepared, gathered or annotated.
>>
>> Litigation privilege is a product of the adversarial process and exists to allow lawyers to prepare their cases with some protection of privacy.
>
> 31 In R.J. Sharpe, "Claiming Privilege in the Discovery Process" in *Law in Transition: Evidence*, L.S.U.C. Special Lectures (Toronto: De Boo, 1984) 163, the rationale behind litigation privilege was discussed (at pp. 164-65):
>
>> Litigation privilege, on the other hand, is geared directly to the process of litigation. .... Its purpose is more particularly related to the needs of the adversarial trial process. Litigation privilege is based upon the need for a protected area to facilitate investigation and preparation of a case for trial by the adversarial advocate. In other words, litigation privilege aims to facilitate a process (namely, the adversary process), ...

RATIONALE FOR LITIGATION PRIVILEGE

> Relating litigation privilege to the needs of the adversary process is necessary to arrive at an understanding of its content and effect. The effect of a rule of privilege is to shut out the truth, but the process which litigation privilege is aimed to protect – the adversary process – among other things, attempts to get at the truth. There are, then, competing interests to be considered when a claim of litigation privilege is asserted; there is a need for a zone of privacy to facilitate adversarial preparation; there is also the need for disclosure to foster fair trial.
>
> ...
>
> 35 All of this jurisprudence confirms that litigation privilege only applies to a document if that document was created for the dominant purpose of use in actual, anticipated or contemplated litigation. Litigation privilege is a product of the *adversarial process* and exists to provide a lawyer with a zone of privacy into which "opposing" adversarial parties cannot pry.[20]

Then, after comparing the nature of inquests in various provinces and territories, Justice Steel described a process that essentially mirrors a public inquiry:

> 47 Thus, an inquest is designed to be an impartial, non-adversarial and procedurally fair, fact-finding inquiry committed to receiving as much relevant evidence about the facts and issues surrounding the death of a community member as is in the public interest, but without making findings of criminal or civil responsibility.[21]

She concluded that this type of process did not attract litigation privilege:

> 61 Let me be clear. I have found that it was an error of law to apply the doctrine of litigation privilege to a proceeding which is not litigation and in which there are no adversaries from whom these documents need to be shielded. I need go no further for the resolution of this point.
>
> ...
>
> 109 The contents of these interviews are not privileged or confidential. An inquest is not litigation in the sense that there are adversarial parties engaged in a dispute. There is no evidence that the witnesses themselves,

> as opposed to the unions, had an expectation of confidentiality. The inquest judge and the reviewing judge erred in law when they held that Crown counsel was no different than a solicitor preparing an ordinary case and that these notes fell within the doctrine of work product privilege.[22]

There are no litigants in a public inquiry. We had done our utmost to devise a process that was inclusive and non-adversarial and to help Participants to shift away from seeing themselves as litigants. As we discussed above, this shift can be difficult. For future inquiries, we would therefore suggest that commissioners resist the assertion of litigation privilege claims relating to the subject inquiry.

> We suggest that future commissioners resist litigation privilege claims, where the basis of such a claim is that the document was prepared in contemplation of their inquiry.

Redactions Process

Protocols for Redactions

Members of the Commission counsel, investigations, research and policy, and document management teams reviewed (incoming) document production to prepare it for (outgoing) disclosure to Participants. In the course of doing so, they vetted it for the usual legal reasons, such as personal information, privilege, and relevance (using the *Inquiries Act* test of "requisite to the investigation"[23]). In addition, the Commission created a protocol for withholding or redacting, at least on a preliminary basis, material that garnered heightened privacy or graphic content protection.

Pursuant to the Commission's mandate requiring us to adopt a trauma-informed approach, we balanced the security, dignity, and privacy interests of individuals with the principles of transparency and openness we had established in order to operate in the public interest. To that end, **our protocol stated that where documents contained information that was potentially harmful to the security, dignity,**

and privacy interests of individuals or where they contained graphic images and/or potentially traumatizing images or information, the identities of individuals and/or the content may be redacted or withheld.

This same balance applied to issues involving security, where the disclosure of information could potentially endanger the physical or emotional safety of an individual or individuals, including through traumatization or retraumatization, and to issues involving dignity, where the disclosure of information could potentially demean or devalue an individual or individuals. An individual's or a community's privacy was similarly affected where the disclosure of information could be an affront to their dignity. The Commission anonymized several witnesses as a result of this protocol, which was based on the principles articulated in the Supreme Court of Canada's decisions *R v Quesnelle* (2014)[24] and *Sherman Estate v Donovan* (2021).[25] Those witnesses were given initials such as AA or BB.

In order to balance the privacy and dignity of those whose information would be protected by redactions with the Commission's core values of openness and transparency, Participants who asserted that they needed to see content beneath redactions in order to participate meaningfully in the Commission could write to Thomas Cromwell, the director of Commission counsel, and request access. The Commission received very few such requests.

Where a redaction was appropriate, the Commission did not simply "blackline" text or images by transposing an opaque black box on top of the text. Instead, the Commission developed a redaction code that explained each one. If the redaction codes started with *V*, for example, that meant the blacklining originated with the RCMP or the Department of Justice. Redactions placed by the Commission were accompanied by *C* codes, described below, and were adapted from nationally accepted vetting codes.

C1 Personal Information

1. *Personal information*: This protection applies to individuals only, not corporations or associations. Examples include personal (not work) addresses, personal (not work) email addresses, personal phone numbers, driver's licence and health card numbers, blood type, medical details, and FPS (Fingerprint Section) numbers from criminal record checks.

C2 Privileged Information

1. *Solicitor and client privilege*: This privilege applies to communications between a lawyer and client, the purpose of which is to give or receive legal advice. If the privilege did not belong to the Commission, then the Commission notified the privilege holder and the document was dealt with according to the Rules of Practice and Procedure. .
2. Canada Evidence Act *privileges*: These privileges overlap with many of the other categories on this list. Specified public interest privilege may apply to information about confidential informants; investigative privilege (for ongoing criminal investigations); the safety of officers and individuals, including witnesses, victims, and employees; sensitive police investigative techniques and information; and internal police communications and intelligence. There are also statutory privileges covering cabinet documents and national security matters.
3. *Informer privilege*: This privilege is used to protect and prevent anyone from revealing information that might compromise the identity, safety, or security of a confidential informant, a person giving a Crime Stoppers tip, or someone within the Source Witness Protection Program.
4. *Protection of young people*: This protection is used to prevent disclosure of information that is protected by the *Youth Criminal Justice Act*.[26] Any names of young people were to be vetted and replaced by first and last initials only, and their photographs were not to be disclosed.
5. *Child protection information*: All information that could identify a child as the subject of or a witness in a child protection proceedings was redacted (including parents', foster parents', and relatives' names).
6. *Ongoing criminal investigation privilege* (belonging to law enforcement): If reviewers saw evidence related to an ongoing investigation by a government body, they were to notify Commission counsel to determine whether paragraph (g)(ii) of the Order in Council was engaged. Paragraph (g)(ii) required the Commission to ensure that our work did not "jeopardize any ongoing criminal investigation or proceeding or any other investigation."

C3 Delayed Disclosure (information that is privileged for a limited period)

1. *Investigative privilege*: The Commission used this privilege sparingly only on its own materials and when disclosure had to be delayed because of sensitive pre-hearing investigations. Withholding this information was temporary.

C4 Irrelevant Information

1. Information that was not requisite to the Commission's investigation – for example, information that was not connected to the Commission's mandate.

C5 Graphic Images or Potentially Harmful Information

1. In keeping with the direction to conduct its mandate in a trauma-informed manner and out of respect for the victims and others most affected, graphic images or materials that could cause further harm by becoming public were redacted using this code.

The Commission used special software to redact audiovisual material for graphic content and where information provided by minors needed to be redacted.

Our document management team conducted a first-round redaction review before sharing materials with Participants, who had all signed a confidentiality undertaking, meaning that they could not share information with others until the Commission made the information public. The team was under significant pressure to review a substantial amount of material quickly, so members made every effort to identify and complete redactions as appropriate. It was neither possible nor crucial at that stage, however, to catch and input every necessary redaction, given the undertakings of Participants not to share information. We asked Participants to identify further redactions that were required on the basis of the criteria set out above.

When we later decided to share source materials with the public by posting them on our website, our document management team became responsible for reviewing the materials again with an added level of scrutiny, to ensure that the redactions we made were complete before public release. Now that the audience for this material was anyone who had access to the internet, a closer review had to be

undertaken. The huge volume of material and limited time in which to review it created considerable challenges. Document management staff conducting the second review needed to catch personal information (such as the identity of a minor, telephone numbers, and licence plates) that sometimes appeared in filenames, personal health information, or other materials that needed to be redacted for privacy reasons. Some people had provided interviews to the RCMP which disclosed information about sexual or intimate partner violence. Before the Commission could make that information public, it assigned initials to protect their identities.

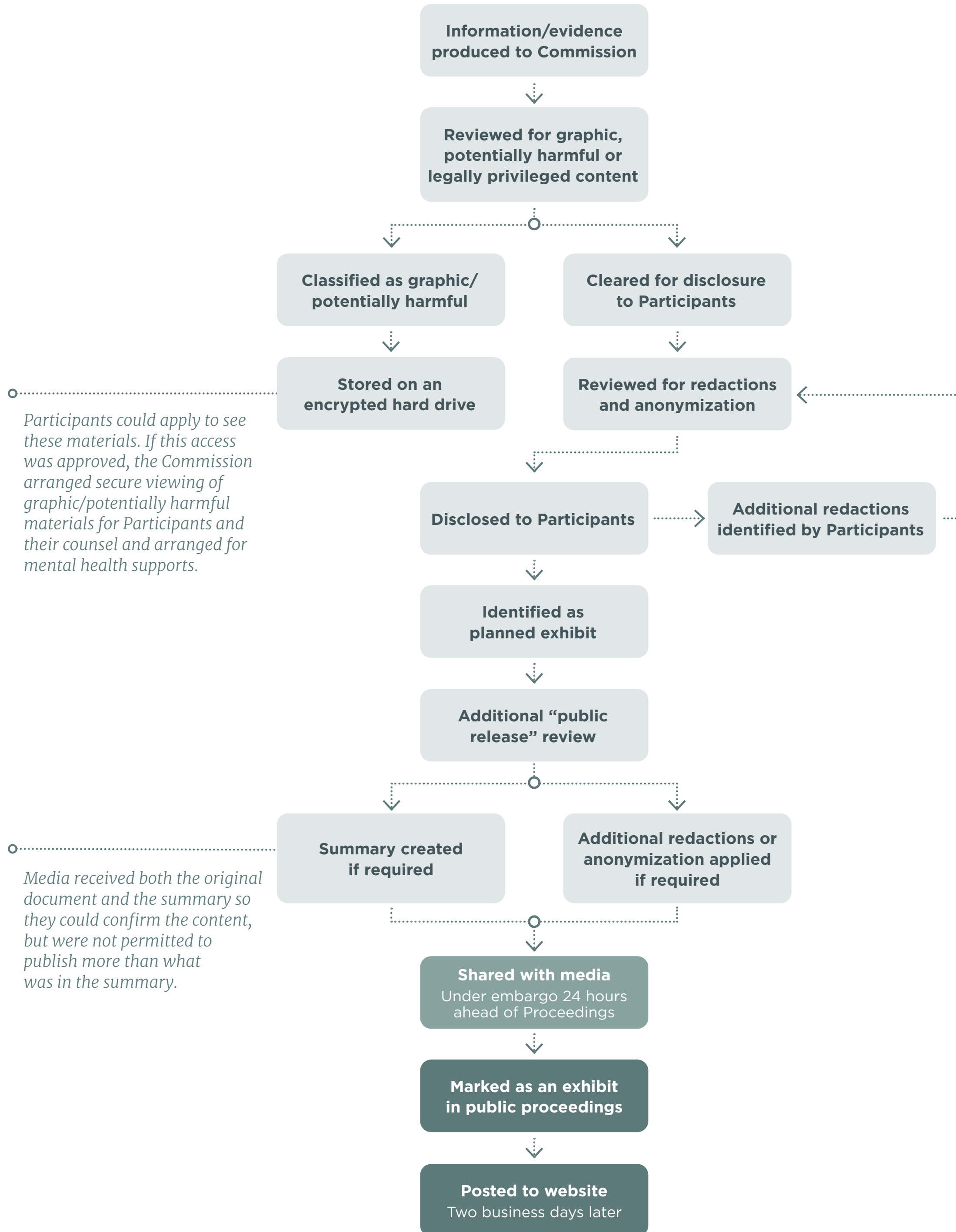
Anonymizing witnesses was also time-consuming, especially if documents had already been released, because the names of witnesses frequently appeared in many places throughout a file. RCMP officers' handwritten notes and redacted material also posed a particular challenge for the document management team because they could not be searched by computer software for names that needed to be anonymized. All this careful work took time, which was in short supply when, in Phase 1, Foundational Documents relying on hundreds of source documents were marked as exhibits each day.

If the Commission learned that materials already posted on our website might include privileged or private information, such as the potential identification of a minor, a civic address, or personal medical information, the document was reviewed and updated without delay. If a more thorough review was required, the Commission temporarily removed the document from our website to review it and reposted it after any redactions had been made. **In short, it was extremely challenging to balance the competing but equally important goals of protecting privacy and privilege interests while ensuring full and timely public disclosure.**

Inquiries must give early consideration to document handling: how will documents be shared, with whom, with what redactions?

- Designate a document disclosure and retention team immediately.
- Staff a dedicated team for document management that is scaled to the needs of each phase of work.
- As a priority, provide redaction criteria to an inquiry's document management team.

Document Production Process



PROTOCOLS FOR GRAPHIC AND/OR POTENTIALLY HARMFUL MATERIALS

The Commission established a system to vet all documents and records for graphic content in order to balance transparency with the privacy and dignity of people who were the subject of various documents (see the C5 redactions above). Accordingly, although Participants were provided with access to all source materials, the **Commission's trauma-informed approach meant that we did not publicly release graphic materials if their evidentiary value did not outweigh the harm that releasing them would cause.** A Commission investigator and assigned lawyer reviewed all documents, ensuring consistency in the classification. For example, images of deceased individuals were classified as graphic, whereas crime scene photos that provided situational information were not (although in some cases parts of the image were obscured). When potentially sensitive and/or graphic materials were disclosed to the Commission, the investigator and the lawyer reviewed them and identified the documents that could be uploaded into the Relativity database and those that should be securely stored on an encrypted hard drive.

Where entire documents were classified as graphic (e.g., a crime scene photograph), they were catalogued with a description of the document, and both the log and the document were stored on an encrypted hard drive. The titles of the documents, which retained the same format as was provided by the Attorney General of Canada, were shared with Participants via supplementary reports. Unfortunately, some of the documents produced to the Commission arrived mislabelled, and that required extra effort to manage when Participants requested access. Although these documents were not automatically disclosed, the Commission created a protocol by which Participants could apply to see materials classified as C5. They needed to state how viewing the unredacted evidence would materially assist meaningful participation in the work of the Commission; the extent to which access might affect the security, dignity, and privacy interests of people not represented by requesting counsel (whose input the Commission might seek); and whether appropriate mental health supports were in place to ensure the Participant had considered the risks of access and would have appropriate support after having had access, if granted. Once this access was approved by the Commission counsel director Thomas Cromwell, the Commission would arrange for private and secure viewings of graphic and/or sensitive materials for Participants and their counsel. Some family members applied to see materials relevant to their loved ones and were granted access to those materials at the Commission's Halifax office.

The Commission maintained strict protocols relating to the storage of these materials and access by Commission staff. The encrypted hard drive was secured in the

Commission's safe at the Halifax office along with a secure laptop for viewing any information on the hard drive. This laptop was protected with a double password and was not connected to the network or the internet. Only one USB port on the laptop was used for the encrypted hard drive.

Another protocol governed the limited number of people within the Commission who had access to these most graphic materials, and access was logged. Access to the safe was restricted to five staff at the Commission, and a small number of Commission counsel and investigators were authorized to access the encrypted hard drive to conduct their work on behalf of the Commission. Other Commission staff required written authorization from the Commission counsel director Thomas Cromwell or Barbara McLean, the investigations director, to access the encrypted hard drive. When authorization was granted, one of the staff who had access to the safe assisted with opening the safe and retrieving the encrypted hard drive, and an investigator oversaw the viewing of graphic and/or sensitive materials. The Commission also maintained an access-tracking log that staff had to sign whenever the safe was opened and/or the hard drive was accessed.

Some counsel for family Participants made good use of the Commission's collection of information to seek answers to questions that had been troubling their clients. For example, Jane Lenehan of Lenehan Musgrave LLP requested that Commission investigators meet with her clients, members of the Goulet family, to answer questions they had about the crime scene where Ms. Goulet died. The Commission held the meeting at the Truro office. Counsel for several other families, from Patterson Law, made requests through the Commission for the return to their clients of the items that had been seized as part of the RCMP investigation, and Commission staff assisted with this task. The Commission also offered to arrange meetings between those most affected with their counsel and the medical examiner's office so that people could learn more about the details of their loved one's death in a private setting, rather than having to seek these answers in public proceedings.

Navigating Challenges with Source Materials

The Commission's Foundational Documents were created based on source material that included:

- institutional investigative files, emails, and other sources of communication;

- Commission interviews with witnesses or people with specific information relevant to our mandate;
- audio and visual recordings and transcripts;
- insights from site visits; and
- policies and procedures.

Before sharing the Foundational Documents with the public, the Commission had to decide whether it would post the source material on its website or, as is more often the case in legal proceedings, make such documents available only in person at a central registry on request. The Commission recognized that one of the reasons a public inquiry had been called was to ensure that the public received information about the mass casualty, that there were ongoing questions about what happened. In certain cases, there was mistrust of the sources of some of the information that had been released outside of the Commission process. The release by a media outlet of the leaked tapes of the 911 calls made by the children of Jamie Blair and Lisa McCully,[27] for example, had made us acutely aware of the scrutiny the Commission would face for decisions we made about how information was shared, both from those who thought every document – no matter how sensitive – should be made public and from those who felt it was harmful to make public detailed information from such a horrific event. Despite such challenges, we remained focused on our principles of independence, trust, and accountability, and we developed robust processes to ensure that materials were made accessible in a responsible way.

The leaked 911 tapes made it clear to us that *how* information was shared required significant consideration, not just *if* it was shared. We determined that it was important to share as many source materials as possible, but in responsible ways that balanced the community's interest in the information we had collected with the privacy and dignity of those whose lives had been taken and those who continued to be affected by the events. We also renewed our commitment to ensure that the pathways to mental health support were clear on our website and in all our public work. In this case, the information on the 911 tape was relevant to what happened, but the identification and distribution of the children's voices on the internet for perpetuity did not protect the privacy of those most affected.

The Commission posted to its website the source documents it relied on in Foundational Documents and all material marked as exhibits. As a result, more than 7,600 documents were made available on the Commission website.

As more subpoenas were issued, the Commission continued to receive additional documents every week. Sometimes the Commission's understanding of a sensitive topic changed as new documents arrived, meaning we had to consider documents that had already been shared in a new light. Counsel for the Participants also identified any material they came across in their review of documents in the Relativity database that required further redactions.

In a small number of cases (less than one percent of source materials from 7,600 exhibits), we directed that material that had been made an exhibit should not be displayed on our website. This decision was made where material in the original document was graphic, contained irrelevant private information of third parties, contained personal health information, or may have been subject to copyright rules. In cases where a summary was posted on the website rather than the original document, the original material marked as an exhibit was provided to Participants and accredited media. On request, the document could also be made available for review to a member of the public. Source materials that were not associated with a specific Foundational Document could be accessed by the public on the Foundational Document page by filtering source material by "Additional Exhibits."

On June 20, 2022, we issued our decision regarding a media application to publish five surveillance videos depicting the encounter between RCMP members and the perpetrator at the Enfield Big Stop on April 19, 2020.[28] The videos were important to our understanding of events, so they had been marked as exhibits in public proceedings. Initially we had determined that the best way to serve the important public interest set out in our mandate to do "no further harm" and to be "attentive to the needs of and impacts on those most directly affected and harmed" would be to make the videos available to accredited media (though we inadvertently left two out). We did so pursuant to an undertaking not to distribute them, and we directed counsel to show still images from the videos, but not the videos themselves, during the presentation of the Enfield Big Stop Foundational Document in public proceedings. On receiving the media request, we sought submissions from all Participants – and none of them opposed the release of the videos, including anyone who may have been directly affected by the publication of these videos on the internet. In light of this response, and with the benefit of independent Commission counsel submissions suggesting that the videos be released, we decided to make them available to the public as source materials for the Enfield Big Stop Foundational Document. We cautioned in a public update that the videos contain scenes of violence, including the discharging of firearms causing death.

Sharing the Information with the Public

Before proceedings began, we wanted to ensure that users could navigate our document library in a simple, effective manner. Our communications team created a search bar on the Foundational Documents subpage in our Documents section. This search function allowed users to filter their search for source materials by the file type of the materials or the related Foundational Document to which it was attached. It also allowed for the use of keywords, so that users could look for specific titles. This search function was in operation before the first Foundational Document became part of the public record, but we did not anticipate the size to which our document library would grow.

Initially, to help the media and members of the public to follow our work, our communications team added source material to the website by hyperlinking individual source materials within the Foundational Documents as well as posting them individually in our source materials library. Once a Foundational Document and its related materials were marked as exhibits during public proceedings, those documents were made available on the website. We created this time frame with transparency in mind – to get the documents to the public as quickly as possible – but we soon learned that this rush on uploading the documents did not allow for time to catch errors in redactions.

Given the importance of getting information out as quickly as possible as well as the sensitivity of the information, document management and posting required significant time and effort. In the early days, we were working so fast to make hundreds of documents available to the public that some needed redactions were missed. Some documents were reviewed and updated on the website without any delay, but, in cases where there was a claim of privilege or private information that required a more thorough review, the document was removed, reviewed, and then reposted. One example of a missed redaction was a cellphone number of a journalist who called us to ask us to remove it; another was an individual's phone number that had been redacted in the document, but remained in the file name. Fortunately, journalists quickly alerted us to these items and we were able to address the missed redactions promptly.

In April 2022, we made a decision to adjust the time frame of uploading source materials. On April 4, we issued a statement explaining to the media and the public that, moving forward, we would need at least two business days for source materials to be added to our website after they had been marked as evidence during

proceedings. This additional time would enable us to review carefully for private or legally privileged information not only the thousands of documents we were posting but also the hyperlinks to the related source materials within the Foundational Documents.

This change in our document management process proved to be beneficial as we began receiving ever larger batches of additional exhibits. Our communications team spent the two days after a document had been tabled as an exhibit in proceedings in reviewing the index included with the batch to ensure that the document titles were clear. In some cases, given the condition of the documents the Commission received, such clarity was impossible. Any document over 5,000 KB was compressed. Once two business days had passed, and the Commission counsel confirmed there were no problems to address, a member of the communications team uploaded the documents to the website. The communications team created a tool to help match the uploaded document to its corresponding title. In addition to creating a tracking sheet to help organize any outstanding source materials and additional exhibits, they sometimes cross-referenced the exhibit list to the source materials library.

Investigations

Concurrent with the document production process, the Commission team carried out an extensive independent investigation. Two key factors differentiated this investigation from a typical investigation in the policing context. First, we had a finite timeline in which to do our work. Second, we were investigating not only to report on what happened but also to make recommendations to try to prevent future occurrences or, should something similar happen in the future, to try to improve the response. To this end, the Commission employed an interdisciplinary approach, with team members, including investigators, looking at the information through their various lenses. Their collective perspectives came together to shape the course of this investigation.

The first task action reports from the Operation H-Strong investigation file, as the RCMP named its investigation of the mass casualty, were delivered to the Commission on March 26, 2021. Applying their professional experience, investigators reviewed and analyzed the contents of this file, which included documents such as police notes and transcripts of witness statements as well as technical reports such as ballistic and forensic reports. Also included were media files with audio

recordings of statements and radio transmissions and images such as crime scene photos and surveillance video files. Although the Commission's mandate did not include an evaluation of the H-Strong file, investigators assessed the information against what would normally be expected of a criminal investigation and requested the disclosure of documents that were not initially produced.

Members of the investigations team did not rely solely on material provided to them; rather, they followed professional investigative practices and sought out additional disclosure, witnesses, and leads. Based on their experience, investigators identified gaps in the disclosure of the H-Strong investigation file. As well, the Commission's mandate went beyond that of a criminal investigation and required dialogue about additional disclosure requests, such as training and policy documents. To facilitate the discussions between Commission counsel and the Attorney General of Canada, an investigator was assigned as a subject matter expert to seek production of missing information and explain why it related to the Commission's work. This practice proved to be a necessary but time-consuming task for the investigations team.

The work of the Commission investigators involved examining what happened, as well as responding to Participant inquiries and, where possible, addressing themes that shaped the public's understanding of aspects of the mass casualty. Below are a few examples of Commission investigations conducted with these purposes in mind.

During the H-Strong investigation, several people who knew of or interacted with the perpetrator made disturbing comments within their statements to RCMP investigators. These comments pertained to missing people, the perpetrator's favour of vulnerable women, the suggestion of a noxious substance, and the perpetrator's ability to dispose of deceased persons. Commission investigators troubled by these themes sought out and secured the perpetrator's Atlantic Denture Clinic patient information as summarized from documents held by the Nova Scotia Public Trustee. Investigators compared patient information to open source / public databases featuring profiles of missing persons and unidentified remains, including missing persons from across Canada. Despite these comments by some who knew the perpetrator, this investigation revealed no connection between the perpetrator and publicly accessible websites related to missing persons.

The perpetrator's financial means and his ability to outfit the replica police vehicle were aspects of the Commission's mandate. An investigator experienced in money laundering and financial crimes examined the perpetrator's monetary practices

that, in part, explained his accumulation of wealth and associated privilege. Specifically, questions arose about the cash seized at the cottage and rumoured sources for these funds. The investigation revealed that the denominations were too large for typical street level drug trafficking, which had been the rumour in the community, and further noted how their packaging suggested they were directly withdrawn from a bank – a process shown to be initiated by the perpetrator. Investigation revealed questionable banking practices that facilitated the perpetrator's ability to redirect business earnings to his personal holdings.

In keeping with anecdotes about sources of the perpetrator's wealth, rumours persisted about the perpetrator being a confidential informant. As such, an investigator experienced in undercover operations, and in the recruitment, handling, and debriefing of confidential sources and police agents, examined the foundation for these narratives. This investigation found no basis to conclude that the perpetrator was an informant or agent and offered a credible public assessment of the evidentiary information within the Commission's vast record. In an effort to educate those following the Commission's work, Commission counsel produced a briefing note on the legislation and case law pertaining to informer privilege, which goes to great lengths to protect the identity of confidential informants.

The investigations team included an intelligence analyst who helped create visual representations of the connections between data / information points, such as interfacing radio calls with maps and preparing presentations or charts to highlight relationships such as dates, times, locations, frequency, and witnesses. This skillset proved invaluable to the Commission's Phase 1 work and is reflected in the many geographic maps and charts contained in the Foundational Documents.

For a variety of reasons, including the public health guidelines restricting travel between regions when most of the investigators were hired, our initial plan for the investigators to live in the Truro area unfortunately did not transpire. We believe that having investigators embedded in the local community would have supported relationship building there and served both the Commission and the community well.

Site Visits

To assess police operational tactics, responses, decision-making, and supervision, investigators made multiple visits to the sites where the mass casualty occurred. These visits took place at various times and in various lighting and weather conditions.

In August 2021, investigators, as well as other members of the Commission, visited Portapique, Wentworth, Glenholme, Debert, Shubenacadie, Onslow, Enfield, and surrounding communities to gather more information about terrain, routes, and locations. These site visits included the use of aerial drones and other camera equipment to take accurate and respectful footage for use during public proceedings and throughout the Commission's work. The Commission used drones because they are efficient investigative tools that save time and require fewer people to operate them. We recorded some of the footage after dark, to replicate the conditions overnight during the mass casualty. The drones traced the routes travelled by the perpetrator. Footage shown during the public proceedings, as part of the Foundational Document presentations, helped the public better understand the rural nature of the area.

While we were aware that the conditions in those communities in the fall of 2021, particularly the foliage in the area, did not match how it would have been in April 2020, COVID-19 lockdown measures in the province prevented obtaining this footage as originally planned in April 2021. The footage recorded during Commission site visits was not intended to represent direct re-enactments. Rather, the images and videos helped to provide context as we established what happened on April 18 and 19, 2020. Image collection was dependent on disclosure, and Commission investigators did this work as soon as they had enough information to determine what footage was required for our proceedings. Communities received advance notice that Commission investigators would be in the areas with drones, given that their presence might be invasive and concerning for residents. To reassure onlookers that Commission staff were in their communities for official purposes, investigators placed Commission signage in the areas as they proceeded. It was important to us to minimize disruption in these communities, and as we intended, we completed this work in one week.

Investigations Supplementary Reports

Part of the investigations team's work during the Commission's public proceedings was to complete investigations supplementary reports to support our overall understanding of the facts of what happened on April 18 and 19, 2020, and how and why the mass casualty happened. These reports represented areas identified by Commission staff or Participants as needing further investigation, and they were regularly referenced as source material in our Foundational Documents. Each report contained the results of further investigation into specific questions or

events, such as Cst. David (Dave) Melanson's failed portable radio transmissions at the Onslow Belmont Fire Brigade hall, the RCMP response in Portapique on April 19, 2020, an examination of the Corrie Ellison homicide scene, the location of the perpetrator's F150, and pathways in the Portapique community.

The Commission produced 38 investigations supplementary reports (Appendix J), which were made available on our website as they were completed. These reports represented the Commission's growing understanding of what happened, and how and why, as we continued to make progress toward developing our recommendations. An invaluable resource, they were regularly relied on by Participants in their submissions to the Commission.

The investigations team compiled another invaluable resource with its review of the Foundational Documents to identify the relevant RCMP policies that would apply to the actions documented. This research allowed an analysis of the degree to which police policies were adequate or outdated, followed, or lacking – an essential aspect of fulfilling our mandate.

Witness Interviews

Witnesses were identified through the collective efforts of the Commission's interdisciplinary teams of investigators, Commission counsel, research and policy staff, and, on more than a few occasions, members of the public engagement and communications team. **Witness leads came through our document review, email responses to inquiries sent to the Commission's website, and our initial mail-out to the most affected communities as well as through other public engagement, including specific meetings with community members on matters that most concerned them.** The investigations director acted as one of the spokespeople for the Commission, and, through media interviews, in social media, and other means, everyone with information was regularly encouraged to come forward.

Commission staff identified a large number of RCMP and non-RCMP employees, along with community members, who had knowledge of matters related to the Commission's mandate. Sometimes interviews were required to clarify witness information, and other times they were required to advance the Commission's forward-focused mandate. In all cases, interviews were designed through a multidisciplinary approach to fill in gaps or solicit information that went beyond the fact-finding process of the RCMP's H-Strong criminal investigation.

Various Commission team members interviewed witnesses, depending on the witness or the nature of the information being sought. For example, investigators conducted and/or attended interviews that focused primarily on police operations, response, decision-making, and supervision. Investigators contacted some people who wanted to speak to the Commission even though they had already provided a statement to the RCMP. Investigators also interviewed people who came forward but had not spoken to the RCMP for its H-Strong investigation.

Commission staff, mindful of the potentially traumatic impact of interviewing an individual again, made efforts to minimize the number of times they asked someone to talk about a difficult subject. A contact management sheet tracked contacts to control for duplicative contacts. Whenever Commission staff spoke to witnesses, they wanted people to be at their best – before, during, and after any interaction. Regretfully, and despite these intentions, the subject matter required many witnesses – residents and first responders alike – to relive distressing experiences first in interviews and then in testimony. To lessen this distress, interviewers involved our mental health team and told witnesses they could attend interviews with counsel or personal support people. In some cases, they proactively connected witnesses to our mental health team when they said they wanted or needed this support.

Where appropriate, we entered transcripts as evidence on the public record rather than eliciting the same information again through witness testimony. By proceeding this way, we were able to include the testimony of many individuals in an effective, efficient manner while also attending to the needs of those who might continue to experience trauma. By the end of our mandate, our integrated teams had carried out more than 250 witness interviews. Transcripts were entered into our public record through Foundational Documents or as exhibits. A complete list of individuals interviewed is included as Appendix K.

Not surprisingly, our fact-finding through interviews faced some challenges. **Unlike subpoena power for document production or for appearance to provide oral testimony, commissions do not have the power to compel people to attend an interview.** Some people we approached did not respond to our team's outreach, including witnesses who resided in Canada as well as those outside our nation's borders who were beyond the reach of the Commission's subpoena powers. For some witnesses within Canada, where we were unsuccessful in getting agreement to interviews, we issued subpoenas for their testimony but were unable to serve them. The interviews were also conducted according to public health guidelines

that included distance and masking, or virtual attendance, creating barriers to building rapport and understanding with witnesses in a compassionate way.

All interviews require a lot of preparatory work, and the serious impact of the disjointed and slow pace of disclosure of materials we requested cannot be overstated. In particular, this delay affected the work of the police context pod, whose efforts continued to the end of the public proceedings. At times, key information, such as a witness's handwritten notes, was disclosed late in the evening before an interview, requiring the interviewers to revamp their approach and work well into the night to incorporate the new information. At other times disclosure came after the interview had been conducted, raising questions that could not be examined as thoroughly as they should have been, given the Commission's time-limited mandate.

The majority of interviews were documented through audio recordings that were subsequently transcribed and prepared for disclosure. This process, although it created extra work involving post-interview review and redaction, enabled us to share these interviews with Participants and with Commission members located across Canada as quickly as possible.

To assist with the collection of requisite information, the Commission developed an informed consent form (see Annex A). This document explained that participation was voluntary and that assisting the Commission was a civic duty that was not compensated. It also let witnesses know that their information would be recorded and transcribed, that it would form part of the Commission's public record, and that under certain circumstances, such as interfering with an investigation or the well-being of others, their information could be shared with the appropriate authorities.

Preparing Foundational Documents in Phase 1

The Commission undertook an expansive and thorough approach to gathering information through document production, investigations, and witness interviews. Early on, the team began to review materials and prepare draft Foundational Documents that distilled and organized the evidence available to the Commission as it was understood up to that point in the inquiry process. (A complete list of our Foundational Documents appears as Appendix L.) The use of Foundational Documents was not unique to this Commission. The Elliot Lake Commission of Inquiry used a

similar mechanism, which it referred to as "overview reports," to establish core facts at the outset of the hearings without having to call witnesses for that purpose.[29]

> We saw the Foundational Documents as a useful tool to assist with navigating a tremendous amount of disparate and otherwise poorly organized material produced to the Commission. They also helped us to share a baseline of factual information that would otherwise have had to be elicited through calling a very large number of witnesses. The use of Foundational Documents considerably reduced the amount of oral testimony required and assisted us in meeting our short timelines while still providing relevant facts to inform findings and recommendations.

We emphasized throughout our proceedings that the Foundational Documents we shared were not the final word on, or conclusion about, what happened during the mass casualty. Rather, they were a basis from which we could build a shared understanding of what happened which could support our inquiry into the causes, context, circumstances, and impact of what happened. Since the Commission's work to collect and analyze all relevant information continued throughout our mandate, our Foundational Documents remained works in progress for as long as we continued our document review and disclosure, investigations, and witness interviews. As we learned more through the course of the Inquiry, we drafted some addenda (to add new information) and errata (to correct errors) for the Foundational Documents. However, because of the large amount of information received later in the mandate, our internal resources did not permit us time to incorporate late disclosure, witness interviews, and other sources of information. Consequently, our ultimate understanding of the factual record is reflected in this Final Report.

Our initial focus was on providing information about what happened during the mass casualty and about certain key topics, such as radio communications, the work done by the Halifax Regional Police and the Truro Police Service during the mass casualty, and public communications during the mass casualty. Establishing a shared understanding of the facts was an immediate priority for the Commission and the community. When we began our work, little was understood about what had happened, and we faced a pressing need from grieving families and communities to provide accurate information to the public as efficiently as possible. Doing so was also an essential prerequisite to move forward with the Commission's

mandate to understand how and why the mass casualty could have happened and to make recommendations to help prevent and respond to similar events in the future.

The preparation of the Foundational Documents was a massive undertaking involving all members of our legal, investigations, and research and policy teams as they assembled the information in a chronological timeline that the public could understand. We essentially "front-end loaded" our process by pulling together all the information that was then available to us into a streamlined narrative, rather than simply releasing huge volumes of unprocessed data. However, we underestimated the time that would be required to produce the initial drafts of the Foundational Documents – largely because of the problems with RCMP disclosure discussed above. For example, the information was not packaged by crime scene or by topic. The Commission had to hire additional staff to organize and code the materials, and the job of reviewing and analyzing them all was monumental. This work all took time, and it hindered our ability to gain an understanding of the evidence sufficient to prepare Foundational Documents with confidence that they were accurate in time for a fall 2021 start to public proceedings.

If preparing foundational documents, inquiries must factor in adequate lead time for disclosure, evidence gathering, analysis, and preparation.

The Commission took care to document where any facts were unclear or where there was materially conflicting evidence, so we could then take additional steps to develop a more complete and accurate understanding. The process was transparent: Participants had access to the document production and other information gathered by the Commission team (such as witness interviews) and could make independent assessments of the information collected within the Foundational Documents. They also had the opportunity to comment on draft Foundational Documents before they were made public. **This early sharing enabled Participants to identify any material gaps or errors in factual information, as well as any additional concerns they had in understanding how and why the mass casualty happened.** We found this input extremely helpful.

The Phase 1 Foundational Documents fall into two categories: location and topic. The location-based documents set out the factual matrix and timeline of what happened at the geographic sites of the mass casualty. The topic-based documents

set out the factual matrix concerning the specific issues, the role of specific institutions, and the structure and interplay of various institutions and programs. These topic-based Foundational Documents provided information relevant to the mandate that extended chronologically from before to beyond April 18 and 19, 2020, and built onto the location-based Foundational Documents that were more focused on the events of April 18 and 19, 2020.[30] The division between location-based and topic-based information separated and clarified overlapping actions, decisions, capabilities, and policies and the resulting consequences. Together the two sets of Foundational Documents were designed to provide a thorough factual basis for the Commission's inquiry into the mass casualty.

As noted, the Foundational Documents enabled the Commission to present information to the public right away, rather than delay until the end of our process. Without the Foundational Documents, the public's wait for answers would have been far more prolonged. Very little information had been shared with the public before we published the Foundational Documents, allowing various theories about what happened to circulate in the community. The Foundational Documents were able to dispel some theories and confirm others. Furthermore, they enabled those who were interested in the facts, or in a particular question, to delve more deeply, especially because the Foundational Documents were posted to our website along with all their source materials.

We sought to prepare comprehensive documents written in a style accessible to the public. The presentation of the Foundational Documents in public proceedings required an enormous amount of work – not only to prepare the documents and thousands of source materials but also to craft effective audio and visual aids to assist the public with learning what the Foundational Documents contained. These presentations required many hours of collaboration between the Commission counsel team and the communications team, among others, to provide an accessible picture of a vast amount of material. We believe that these presentations, the webcasts of which are available on the website, enabled the public to learn about what we were learning as we went along. At the outset, we reminded Participants and the public that the presentation represented a summary of what the Foundational Documents and related source materials contained. We emphasized that our having summarized the facts should not be interpreted as our having treated those facts with less importance. In addition to the Phase 1 Foundational Documents, the Commission prepared a similar series for Phase 2.

FOUNDATIONAL DOCUMENTS – PHASE 1

Location-Based

- Portapique, April 18 and 19, 2020
- First Responder Actions in Portapique
- Containment Points in and Around Portapique
- Overnight in Debert
- 2328 Hunter Road
- Highway 4, Wentworth
- Highway 4, Glenholme
- Plains Road, Debert
- Onslow Belmont Fire Brigade Hall
- Shubenacadie
- Highway 224
- Enfield Big Stop

Topic-Based

- Police Paraphernalia
- Confirmation of Replica RCMP Cruiser
- Firearms
- Alert Ready in Nova Scotia
- RCMP Emergency Response Team
- RCMP Command Post, Operational Communications Centre, and Command Decisions
- Truro Police Service, April 19, 2020
- RCMP Public Communications, April 18 and 19, 2020
- Air Support
- Halifax Regional Police and Halifax District RCMP Operations
- 911 Call-Taking and Dispatch
- TMR2 Radio Communications System in Nova Scotia
- Public Communications from the RCMP and Governments After the Mass Casualty

The Foundational Documents proved to be a critical feature of the Mass Casualty Commission. They were an effective mechanism by which the Commission could share in a timely and transparent way both the information and the evidence we had obtained to that point as well as our understanding of that material. The documents were "foundational" because they provided the Commission, Participants, and the public with a base from which to identify the next level of "how and why" questions – questions that informed the work of Phase 2 – in a timely way.

Input from Participants and Working Meetings

The Commission engaged Phase 1 Participants in a series of working meetings to provide their input on the Phase 1 Foundational Documents. These meetings took place over several weeks in November and December 2021, with the goal of ensuring the documents' accuracy before their presentation in public proceedings in early 2022. In advance of the working meetings, Commission counsel met with Phase 1 Participants to outline the process for the upcoming sessions. Commissioner MacDonald provided introductory remarks to thank the Participants for their continued engagement and to seek their collaboration with the challenging work of the Commission.

Drafts of the Foundational Documents were sent to Phase 1 Participants on a confidential basis as they were prepared, beginning in late August 2021. Initially, we asked for written comments from Participants' counsel, with a view to receiving their input and finalizing the documents in time for the public proceedings first scheduled for the fall of 2021. By September 2021, it became clear that RCMP document production was being received more slowly and in a less organized manner than we had anticipated. We recognized that more time was accordingly required to review source materials and complete the Foundational Documents. We revised our schedule to allow Participants and Commission staff to perform the necessary review and analysis.

Commission staff as well as the Participants and their counsel had set aside time, and we had booked meeting space in anticipation that the public proceedings would begin in November 2021. We decided to make effective use of this time and space and keep our process moving by holding working meetings where Participant and Commission counsel could carry out a joint review of the Foundational Documents. Participants interested in or wanting to make a contribution to Phase 1

matters were invited to hear what other Participants had to say, and feedback was encouraged.

These meetings served two purposes. First, they were a dedicated opportunity for Participants to provide input on the content of the draft Foundational Documents, helping to ensure that they were as accurate as possible before being shared with the public. Second, we sought Participant input and insights on aspects of the factual account which required clarification, explanation, and exploration during the Phase 1 public proceedings. This feedback helped us to determine how best to use hearing time, with the focus on what the public needed to understand, as a basis for the work in Phase 2 and Phase 3. Each meeting was structured around a specific Foundational Document, and we directed that the same questions be asked:

- Are there gaps in the information?
  - if so, please identify the gaps you see;
  - tell us why that information is important to learn / understand;
  - if there is a gap requiring more detail, who should we hear from?
- Are there inaccuracies or other perspectives relating to any of the information, and why are the other perspectives important? What information are you aware of that forms the basis of your view on the content of the document?
- Are there areas that require more attention or detail, and why? If there is an area requiring more detail, who should we hear from?

The working meetings operated on the principle that we would be sharing credible facts with the public. It would have been irresponsible to publicize this information prematurely. Meetings were held on a "without prejudice" basis, which in this context meant that Participants were not giving up any rights, including the right to give an independent assessment of the Foundational Documents later in the process. These meetings were confidential to encourage open and candid discussion among Participants in the service of reaching a clearer understanding of the facts and issues. Transcripts were not produced, and recordings were not permitted. It would have been irresponsible to publicize this information prematurely for two reasons: first, those most affected were still reviewing the material themselves; and, second, the information in the Foundational Documents required further review and revision to ensure its accuracy.

Commission counsel moderated each working meeting, helping to make sure that all voices were heard in a fair and respectful manner. A meeting was not a

mediation or negotiation. It was an opportunity for Participants to give input orally rather than in writing, and to do so in the presence of other Participants. The collective format meant that Participants could learn from one another and that, in sharing their questions, some concerns could be allayed and others could be flagged for further investigation. We recognized that there were some conflicting interests among Participants and took steps to explain and model the non-adversarial character of this process (and of the Commission process overall). Since the adversarial model is so entrenched as the default process for lawyers, it was necessary for Commission counsel to reinforce the inquisitorial process and address apparent misunderstandings among Participants continually throughout the working meetings. This required clarifying the role of Commission counsel as neutral facilitators who were tasked to gather and analyze evidence in a fair and impartial manner, rather than as prosecutors tasked with finding blame or fault.

Participant counsel attending the working meetings often offered corrections and improvements to parts of the draft Foundational Documents that did not directly touch on the client's interests. It was clear that many counsel were making serious efforts to assist the Commission in its efforts to create accurate, useful documents to assist not only Participants but also the public. For example, Nasha Nijhawan, counsel for the National Police Federation, helpfully shared her knowledge about the organization and operation of the RCMP with others in attendance at the working meetings. Josh Bryson, counsel for the Bond family, asked thoughtful questions about broad systemic issues that may have affected the response to the mass casualty, such as police communications and radio transmissions, to assist the Commission in building a comprehensive evidentiary foundation.

Despite our hope that the meetings would be positively received as a constructive step forward, some family Participants objected to their confidential nature. They protested that they, the media, and the public could not attend. They were understandably anxious for the public proceedings to begin, but could not yet know how much work had to be done before that could happen. At their request, we adjusted the plan to allow Participants to attend to observe, but did not open the meetings more broadly given the rationale for ensuring a space for candid discussion of a preliminary understanding of the factual record. Some of the family Participants who attended found the discussion among lawyers about facts to be "clinical" and disconnected from the emotional intensity of what was being discussed. Other Participants voiced concerns about already "falling behind" in the review of documents they were receiving just days before they needed to comment on them. This was a challenge we experienced throughout our work owing to the sheer volume of

information and, in this case, it was a reason why it was important that the meetings be without prejudice, so people knew they could revise their views as they received new information or read documents later that had not informed their initial feedback. Mental health support was available for attendees.

Although we Commissioners did not attend the meetings because they were not public proceedings, representatives of the Commission counsel, investigations, and research and policy teams did. Their role was to hear Participants' contributions and to provide clarification as appropriate. Areas where additional investigation might be required or further document production sought were noted and brought back to the Commission for appropriate follow-up.

These meetings were the first substantive opportunity to work in collaboration with Participants. The active inclusion of Participants made a meaningful difference to the Commission's draft Foundational Documents. Although there had been considerable contact between Commission counsel and Participant counsel, these meetings were also the first chance for in-person meetings between Commission staff and Participants and their counsel. Because of public health restrictions due to COVID-19, earlier meetings had all been held virtually.

Following these working meetings, the Commission team created annotated Foundational Documents, collating the feedback provided by the Participants. These documents were reviewed, investigative leads were followed up, errors were corrected, and revisions were made to the draft Foundational Documents by Commission staff who participated, before the Foundational Documents were presented at the public proceedings.

> Providing participants with an opportunity to review and comment on draft foundational documents, and to hear the comments of others, helps to build a shared understanding of both the factual record and the perspective of each participant. This process strengthens the foundational documents and builds a common foundation for public proceedings.

Phase 1 Public Proceedings

In February 2022 we were ready to begin presenting our initial Foundational Documents – in chronological order and on a rolling basis. Although some team members were presenting the first Foundational Documents publicly, others in the office were diligently finalizing those yet to come.

We did not want the Commission's work to drag on for years, because that might only prolong the grieving process for many people. We wanted to move forward as quickly and yet as carefully as possible despite the complexity of our investigations and the challenges presented by problems with document production. Although our scheduling changes were frustrating for some of those most affected and for members of the public who wanted information, they were necessary and were always decided in consultation with Participant counsel who were requesting more time for document review and preparation. Timing would be a persistent issue throughout our work as the Commission team, Participants, and partners (such as interpreters, audio/visual technicians, and security services) were often working very long hours to meet our schedule. **There is a fine balance for inquiries to provide timely information to the public but also to conduct their work in a reasonable and thorough manner.**

Before we opened proceedings, and throughout the rest of our mandate, we were grateful for the guidance of Mi'kmaw Elder Marlene Companion, who helped us proceed in a good way by smudging the space and offering prayers.

Political Interference

Prior to the opening of public proceedings, some family Participants contacted the premier of Nova Scotia to express their displeasure with the Commission's approach. Premier Tim Houston took the extraordinary step of issuing a press release, the "Statement on the Mass Casualty Inquiry – Government of Nova Scotia, Canada,"[31] an hour before we delivered our opening remarks on February 22, 2022. In the statement, the premier said the Commission should meet with the families. He queried whether the public should have confidence in the Inquiry. In a subsequent interview, he indicated he had spoken with some family Participants.

By this time, there were more than 60 Participants in the Inquiry, and we owed our duty to the public interest, not to any particular group of Participants. The premier

stated he stood with the families. He made no mention of the other Participants and their interests in the Inquiry. And yet, the Orders in Council mandated that the Government of Nova Scotia was itself a Participant in the Inquiry and a necessary one given its responsibility for areas including policing, mental health, communication, and rural services in the province. Indeed, family members had launched a class-action lawsuit against the province alleging, among other things, that it failed to provide adequate police resourcing in the affected areas.

This particular example of political interference in the Inquiry was very concerning given its intended message to the public. Nevertheless, we persisted through seven months of hearings, roundtables, consultations, and other public proceedings before closing them on September 23, 2022. (Appendix M is a detailed calendar of the proceedings.)

Purpose and Approach to Public Proceedings

The planning of public proceedings had to take into account our vast mandate and tight timelines. We used the Foundational Documents to distill a mass of material into a navigable narrative, and we planned to share what we knew at that point about what had happened on April 18 and 19, 2020, in the Phase 1 public proceedings (roughly February to April 2022)[32] before the second anniversary of the mass casualty. We asked Commission counsel to present the Foundational Documents in public proceedings, with audio and visual aids (maps, videos, radio transmissions) in order to guide people through the timeline of those two terrible days.

We used the Foundational Documents and the commissioned reports as scaffolding for the proceedings – providing the structure to guide us all through the various parts of the mandate. We also added witness testimony (individuals, experts, panels) and roundtables to contextualize and illuminate the written framework. Where we or the Participants identified material gaps or contradictions in the Foundational Documents, we sought oral evidence from witnesses to assist us in addressing those aspects of the evidentiary foundation. Although our approach was different from that adopted in many legal processes, we viewed it as the only way to assemble an understanding of the facts, causes, context, and circumstances of the mass casualty within the two years as required by the Orders in Council. Had we proceeded in a traditional legalistic manner, by calling witnesses to testify to every fact, however minor or uncontroversial, the breadth and depth

of our mandate would have necessitated several years of testimony and public proceedings.

Regardless of the time pressures, we believe our approach was the appropriate one for many reasons. As discussed above, for example, our use of Foundational Documents allowed us to present thousands of documents relating to April 18 and 19, 2020, so the Participants and the public did not have to wait for the Final Report to learn what happened. This approach, by allowing us to call only those witnesses who were necessary to complete the evidentiary record, helped to reduce or prevent trauma for those who would otherwise have been called. In short, our approach enabled us to complete a thorough public record within the time allotted.

In other tasks, we marked transcripts of witness interviews, investigative reports, legislative and policy briefs, and other materials as exhibits and filed affidavits to reduce the amount of public hearing time required. We would have much preferred to provide an advance witness list for everyone's benefit, but in the lead-up to proceedings it was not possible to predict all the witnesses we might need to hear from in the course of the Inquiry. Aside from the senior RCMP leadership who would provide an institutional perspective once the factual foundation was established, it was not clear when we began our public proceedings where the material gaps in the witness testimony would be. Every tranche of disclosure brought new information, and much depended on having the staff capacity to go through it all and analyze its relevance and importance. Furthermore, we had to be careful not to place potentially traumatized witnesses on a witness list prematurely. (A complete list of witnesses as well as small group session and panel members is found in Appendix N.)

The Commission held a workshop with Phase 1 Participants in late January 2022, before we began the proceedings, to discuss in depth the direction in our mandate to be guided by restorative principles and to work in a trauma-informed way. We wanted to build a common understanding of those principles and how they shaped the structure and processes of our work. Unfortunately, the online workshop did not enable the kind of discussion that might have been possible in person, nor was it attended by some of the counsel who were most vocally opposed to the approach we were taking with our work.

As we have described throughout this volume, this Inquiry incorporated a restorative approach to all of its processes. Yes, the approach was part of our mandate but it is also an accepted way to analyze and address deep problems with systems

while considering the needs of those who are part of the system. As described earlier, this approach has been used in other commissions of inquiry. This restorative approach underscored our goal of seeking the best information that would provide insight into what had happened and how and why it happened. A process that would seek to lay blame or create a public spectacle of someone is unlikely to produce that person's best evidence. In our inclusive approach, first responders were among those most affected, and they are also the people who we want to answer the call when the next critical incident happens.

> The needs of all those most affected are served if we act in the public interest and create an environment conducive to learning from the past in order to do better in the future.

An inquisitorial approach accepts that there are many ways to seek reliable information, and cross-examination of witnesses is often not the most effective means of getting people to be forthcoming with their evidence. Some Participant counsel were critical of our approach, even though they had the opportunity to question witnesses within the scope of their interests except in a very few cases where we required counsel to provide their questions via independent Commission counsel (as described in the "Witness Accommodations" section below). It was not necessary to call witnesses to appear in a public forum if we could obtain their evidence in some other reliable manner. We assembled a robust evidentiary foundation on which to make our findings and recommendations through a variety of means, including dozens of Foundational Documents based on the review of many thousands of source materials, affidavits, investigations supplementary reports, more than 250 interviews, and the testimony of 60 witnesses.

Focus on Mental Health and Rural Communities

From the outset of our work, we had evidence of the ongoing impact of the mass casualty on the affected communities and on the mental health and well-being of those most affected. Although the proceedings had to focus quickly on what happened and publicly share the evidence we had amassed, we decided on the opening day to recognize where this mass casualty had occurred and its continuing impact.

On February 22, 2022, therefore, we focused attention on individual and community trauma, resilience, and wellness by hosting a panel discussion about "The Human Impact – Broad Reach and Impacts on Wellness Context." The purpose of this panel was to acknowledge the ripple effect that the mass casualty precipitated – a ripple that was felt not only by Nova Scotians but also by people across the country and beyond. We also knew that more people would be affected by the details the Inquiry would share over the weeks and months to come. The panel recognized that since April 2020, some people had been thinking about the mass casualty every day, while others may not have thought about it since it happened, either intentionally or unintentionally. Members of the community who were paying attention to our work were at different places along this continuum.

With this panel, we hoped to help convey the breadth of people and groups affected by the mass casualty, to help normalize and validate emotions people had felt or were feeling, and to help community members prepare for the information to come from the Commission's work. We hoped through this discussion to destigmatize talking about mental health and to normalize seeking access to wellness supports. The panel included mental health professionals and advocates with a range of backgrounds from community, provincial, and national organizations.

The second panel that day, comprising a cross-section of community representatives, introduced important contextual information about the rural communities in which the mass casualty took place – what the people and places are like, what makes them special, and the attributes they share with other Canadian communities. The Commission had in its public proceedings to provide context to the factual analysis contained in our Foundational Documents to an audience across Canada and beyond, so it was critical to give this information about life in rural Nova Scotia. The panellists also helped us remember that their communities are far more than just the locations where this mass casualty occurred.

We anticipated sharing a considerable amount of information with the public in 2022 through our proceedings, Foundational Documents, and commissioned reports, and the nature of our Inquiry meant that much of that information was difficult. Mental health supports were available to anyone attending public proceedings in person. We strongly encouraged anyone who was engaged in or following our work to consider how and when to receive the information we were sharing. We noted that recordings of the webcast were available on our website so that individuals could watch the proceedings at a time, place, and pace that worked

best for them. Those recordings could be paused, fast-forwarded, and rewound by the viewer.

We recommended that everyone engaging with the Commission's work familiarize themselves with the mental health and wellness supports that were available to them, including those listed on our website,[33] and that individuals experiencing distress or overwhelming emotions call the 24-hour Nova Scotia Provincial Crisis Line. After receiving feedback about the stigma of calling a crisis line, as well as the long wait times of an under-resourced system, we began to also advise members of the public that they could call the Kids Help Line or the 211 phone line, or visit the website. The 211 service offers full-time navigational assistance to a range of services in more than 100 languages[34] – though not, we learned, in the first language of the Mi'kmaq, the largest Indigenous population in the province. Although the trained 211 staff can connect individuals directly to the services they require, we heard throughout our work that the mental healthcare system in the province is overwhelmed.

Before proceedings closed on the first day, the Commission provided an orientation to our website and other resources to support and assist members of the public who were following the proceedings. We were committed to making the information accessible in whatever way and at whatever pace people might be able to receive it.

> Where inquiries deal with subject matter necessitating mental health supports for participants, we suggest they hire staff who know the available services very well so that they can help others navigate and access the systems. Commissions cannot be mental health service providers, and they are short-term mechanisms; people need to be connected to the resources that can assist them continuously and in the long term.

Accessibility of Public Proceedings

Because of the constantly evolving COVID-19 situation in Nova Scotia in the early months of 2022, we made plans for some or all of our proceedings to be done virtually rather than in person. Working with our event manager, we assessed

potential sites but we also received feedback that some people, fearing reminders of the mass casualty, did not want the Commission, media, or the police coming to their town. In the first two months, other locations were unavailable because they could not provide an option for social distancing for people connected to the Commission or people wanting to attend our sessions. Finally, we chose the Halifax Convention Centre for both the opening session and the succeeding two months. It provided the space to follow public health protocols and allowed most people interested in attending to register day by day. This venue also met the complex technological standards we required for our proceedings.

As the opening day drew closer, our staff set out to help prepare Participants for what to expect. They offered tours of the venue, particularly to show how the space would be set up. They arranged a similar tour for the media. They also prepared a background package for families, which was communicated through Participant counsel.

In the ongoing spirit of transparency and accessibility, we wanted to ensure that our public proceedings were available to anyone interested in following them – and on their own time.

The proceedings were webcast live, with French and American Sign Language (ASL) interpretation and captioning using Communication Action Real-Time Transcription (CART), and the webcasts were archived on our website, which permitted viewers to follow the proceedings at their own pace. The Commission also made transcripts of the proceedings available on our website. Knowing that not everyone has available access to the internet, we also offered a toll-free telephone line. Members of the public could call in to listen to the public proceedings live, in English or in French.

We conducted public proceedings in various locations in Truro, Halifax, and Dartmouth, and also virtually. We provided assistance to Participants who wished to attend in person, including covering their travel costs. At the start of proceedings, the Commission established a community viewing site at the Inn on Prince Hotel in Truro, where members of the surrounding communities could gather to watch a live webcast of the proceedings that were being held in Halifax. It had a reliable internet connection, a maximum capacity of 100 people socially distanced, and, like all our proceedings, offered mental health supports as well as Commission staff and security on site.

After the first four weeks of public proceedings, in late March 2022, we decided, given the low attendance, to close the Truro community viewing site. We continued to monitor the needs of communities and offered other viewing options for anyone who was interested. We were prepared to host people in the Commission's Truro office if small groups requested it or to find another venue if needed.

Structure of Public Proceedings

The Commission's public proceedings began on February 22, 2022. For the most part, these took place Monday to Thursday between 9:30 am and 4:30 pm ADT, with a 60-minute break for lunch and a brief break in the afternoon. Other breaks were scheduled in the calendar, including one in mid-March and one in August 2022. As noted, the public proceedings were held at different locations in Truro, Halifax, and Dartmouth.

We began each day of public proceedings by honouring the memories of those whose lives were taken during the mass casualty. We shared their names on a large screen at our in-person proceedings and on the webcast during a moment of silence. Every day we also delivered brief opening and closing remarks to orient people attending or watching to the nature and content of that day's activities.

On the first day, we Commissioners made more lengthy opening remarks.[35] We discussed the purpose and approach of the Mass Casualty Commission, the phases of the Inquiry, the Participants, the role of the public, and what to expect during the public proceedings. We explained the restorative approach of our Commission – non-adversarial, collaborative, inclusive, responsive, and forward looking. We emphasized the important differences between public inquiries and civil and criminal trials and the fact that the Commissioners and all members of the Commission team act in the public interest. We explained the three phases of the Inquiry and our focus on investigating what happened on April 18 and 19, 2020, understanding the broader context and related issues that may have contributed to the mass casualty, and providing meaningful recommendations to help protect Canadians in the future. We indicated that there were more than 60 Participants, including the most affected individuals, families, first responders, and organizations.

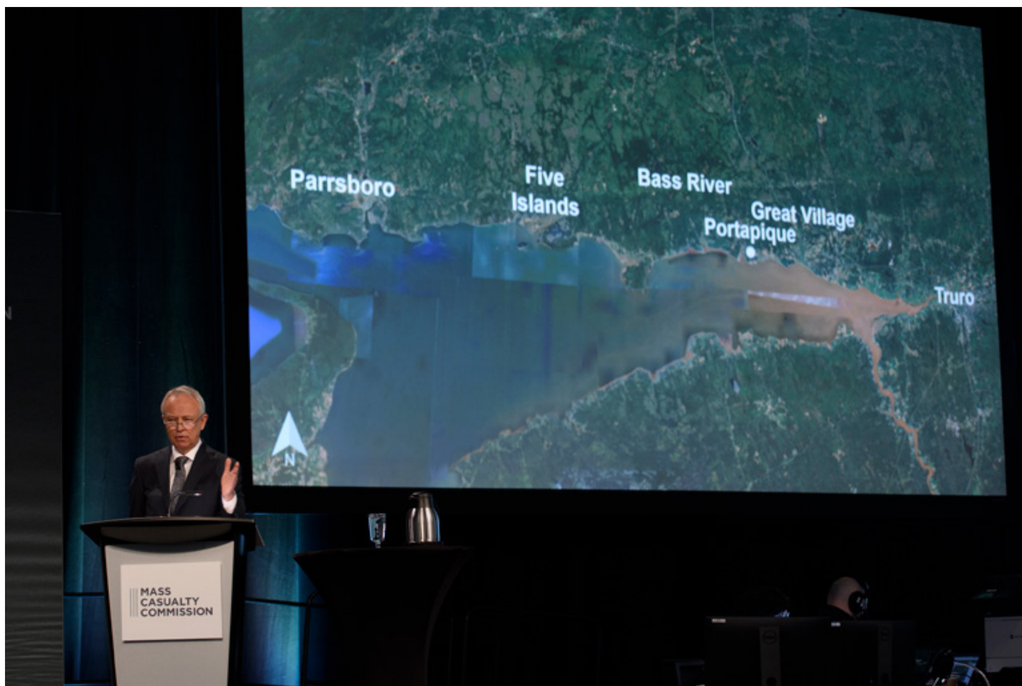
We strongly encouraged the public to be engaged in our Inquiry and to provide input, such as contacting the Mass Casualty Commission if they had information that could assist the investigation, taking part in the public proceedings,

participating in the Share Your Experience survey on the Commission website, and offering suggestions for the recommendations.

Expanding the Evidentiary Foundation

In Phase 1 of our public proceedings, the Commission introduced location-based Foundational Documents to share what happened on April 18 and 19, 2020, with a focus on the critical incident response. We supplemented the presentation of these Foundational Documents with witness testimony in our public proceedings.

After sharing our location-based Foundational Documents and hearing from related witnesses, the Commission began to present our topic-based Foundational Documents. Because of the delay in starting the proceedings, we shifted to an approach that integrated an additional range of public proceedings, including hearing from expert witnesses and convening roundtables. This transition to Phase 2 began the exploration of how and why the mass casualty happened,



Roger Burrill, senior Commission counsel, presenting a Foundational Document during public proceedings.

organized around the work of the Commission's pods. It gave us the flexibility to hear and share various types of information and experiences in a comprehensive, orderly, and timely manner.

S/Sgt. Jeff West (ret.) and S/Sgt. Kevin Surette (ret.) sharing information with the Mass Casualty Commission during public proceedings.

In 31 Foundational Documents presented over the course of our mandate, the Commission shared with the public the evidence we gathered through 109 document subpoenas, more than 250 witness interviews, and numerous site visits. The Commission presented these documents in chronological order following the timeline of the mass casualty. Multiple media, including maps, graphs, and modelling, along with 911 transcripts, audio files, and information provided by community members, were integrated into these presentations to further an understanding of what happened on April 18 and 19. Through the presentation of these Foundational Documents, the Commission shared with the public our understanding, to that date, of what happened on April 18 and 19, 2020. This included sharing 911 transcripts, audio files, and information provided by community members. Over the course of the proceedings, we continued to call on witnesses to provide technical or human context and to address gaps or factual conflicts in the Foundational Documents. The Commission's extensive, independent, and ongoing investigation efforts, as well as the additional information being received through our disclosure process and from the community, also continued to inform our understanding of the facts throughout the course of the Inquiry. It was important, however, for the public to have an understanding of what our investigation had produced by early 2022, in order to ensure that the relevant questions were asked about how and why the mass casualty could have happened. However, only the Final Report would include our full findings and conclusions.

This integrated approach to public proceedings meant that, throughout Phase 2 in the late spring and through the summer of 2022, days of witness testimony were interspersed with days of roundtables. The substance of these proceedings is described below in the section on the three thematic pillars around which we organized our work.

Unlike in other legal processes, the Commission collected documents at the same time as we were both interviewing witnesses and calling witnesses during the public proceedings. Inevitably, related information rolled out on the same topics in different ways and on different timelines, and in some cases, new information shed light on information we had previously received.

Exhibits

Over the course of our public proceedings, the Commission provided Participants with a list of anticipated or identified exhibits in advance of referring to them in proceedings. This process was governed by Rule 46 of the Commission's Rules of Practice and Procedure, which related to documents in hearings. Rule 46 provided:

> In advance of a witness's testimony, Commission Counsel shall provide the Participants with reasonable notice of a list of the documents associated with the witness's anticipated evidence in chief. Where possible, in advance of a witness's testimony, Commission Counsel shall provide the Participants with an anticipated evidence statement or witness interview summary.[36]

The Commission used a Rule 46 Anticipated Evidence Overview or an information sheet to provide details about upcoming witnesses and exhibits to Participants.

Under Rule 47, Participants were asked to provide Commission counsel with any documents they intended to file as exhibits or otherwise refer to during the public proceedings at the earliest opportunity or no later than the day before the document would be referred to or filed. Any documents identified were flagged for review by the Commission's document management team for possible redactions before sharing them publicly in proceedings. If a document was not identified with sufficient advance notice to allow time for a redaction review, it was not shown on screen during public proceedings but was added to the Commission's website after the review for any appropriate redactions was completed.

Anticipated exhibits that were identified in advance of proceedings were sent to the media via the Commission's secure file-transfer system, and were under embargo (meaning media could not publish information related to the anticipated exhibits) until the materials were properly filed as exhibits by Commission counsel

during public proceedings. Where possible, the Commission shared anticipated exhibits with the media two days in advance of proceedings.

When materials were marked as exhibits by the Commission during public proceedings, they were shared with the public on the Commission's website no sooner than two days after exhibiting. This allowed time for the document management team to complete a redaction review, and for Participants to flag any redaction concerns.[37]

How We Heard from People

Thousands of people had information related to the mass casualty – as witnesses who saw or heard something on April 18 or 19, as first responders or survivors, and as those who lost a loved one or who had information about the perpetrator's firearms, vehicles, and past activities, to name but a few. We knew that in the limited time we had to complete this work, we would not be able to hear in the public proceedings from every person with important information to share.

We also knew that answering questions on a stage in public is not always the best way to hear from people, many of whom would provide their information more effectively in an interview with a member of the Commission's investigative, legal, or research and policy teams. That dual system also allowed many more people to give information to the Commission. These interviews could happen in person or virtually and were transcribed. Often someone being interviewed suggested someone else the Commission should talk to, and this generative approach allowed teams within the Commission to pursue information relevant to their particular focus. Because the Commission shared all its source materials, including the transcripts of the interviews it conducted, on its website, the information from the interviews was made public, just as it would have been if the person had been called as a witness in proceedings. Moreover, having access to interviews the RCMP had conducted allowed the Commission, in cases where there was no reason to doubt the version of events or seek more details, to rely on that information without asking someone to tell their whole story over again.

The Commission determined it would hear from people for different purposes over the course of the Inquiry in ways that seemed appropriate. Oral evidence was necessary when it could add to the factual record in a meaningful way, especially in areas where there were gaps or conflicting evidence on important issues.

Throughout the proceedings, Participants were asked to identify such gaps or conflicts and to suggest witnesses whose oral evidence would assist the Commission. We carefully considered all their oral and written submissions.

As an inquisitorial process, the Commission sought to learn as much as it could from each witness, including the connections between their evidence and other information the Commission was collecting. As set out in Rule 50 of the Commission's Rules of Practice and Procedure, Commission counsel could ask witnesses both leading and non-leading questions to bring out such information. **Participants had a role to play in questioning witnesses, as related to their interest in the mandate, but that did not include an automatic right to question every witness.** Some Participants' counsel were more familiar with adversarial legal processes where opposing sides present the relevant information to a neutral adjudicator. In that system, cross-examination is the primary way to question a witness who is presenting information against a party's interest.

> Cross-examination involves asking narrow, frequently leading questions, and it is often less helpful for the types of questions the Commission is required to answer in its mandate, such as identifying the causes, context, and circumstances giving rise to the mass casualty, the lessons that can be learned from them, and the recommendations to try to prevent and respond to similar incidents in the future.

To ensure that the Commission had the opportunity to learn from each witness, we invited Participants to collaborate with us. First, Participants provided areas for questions to Commission counsel to explore during their direct examinations. This process ensured that Commission counsel could address areas of concern or interest to Participants in an efficient way, rather than having the witness answer a series of repetitive questions from counsel for many different Participants. Counsel for Participants also collaborated with each other by meeting after Commission counsel had finished their questions to identify areas that required further exploration and to identify which counsel would ask the questions. The system proved to be not only efficient but also helpful for witnesses, especially those who were publicly reliving their experience of or involvement in the mass casualty.[38]

Questioning Witnesses

The Commission advised Participants why a particular witness was being called in advance of their testimony. The Commission also informed Participants which documents they considered relevant to a witness's anticipated evidence. This process was set out in our Rules of Practice and Procedure. After Participants received the information about a witness (including technical witnesses), they could advise the Commission if there were additional areas they wished to explore and whether they wanted to question the witness themselves. Participants could also provide additional documents they wanted the witness to address.

Commission counsel collaborated with Participants in their planning for witness questioning. After Commission counsel finished their questioning, the witness was given a break and Participant and Commission counsel met (in a "caucus") to identify areas for further questions. Counsel for the witness participated in the discussions, and all counsel worked together to determine what questions fairly remained unanswered, who would ask them, and in what order. The discretion of the Commissioners set out in Rule 52 meant that if Participants were unable to agree in their caucus, they had the opportunity to make any outstanding requests to question the witness directly to the Commissioners. However, this right was never necessary following a caucus. Commission counsel reported the consensus reached in caucus to the Commissioners before proceedings resumed, and we consistently approved the plan agreed to by counsel. If we had not approved the plan, it would have been resolved in public proceedings. Any disputes not resolved in caucus were resolved in open proceedings, such as, for example, objections to particular questions.

Proposed Witnesses

Participants made submissions in public proceedings in early March 2022 about 27 witnesses they wished to hear from who were connected to the content of the first three Foundational Documents and could help to build the factual foundation of what happened. On March 9, 2022, the Commissioners issued a decision about a number of witnesses who would appear during our proceedings to provide oral testimony.[39] Our decision also directed that affidavits from some people be prepared and provided to the Participants. It set out a number of witnesses who would be scheduled soon after the decision was released as well as witnesses who would be called later in the proceedings:

- Lisa Banfield, the perpetrator's common law spouse, who had begun a series of interviews with the Commission in March 2022. The Commission anticipated that it would hear from her to address remaining questions or to provide important context later in our process.
- Cst. Stuart Beselt, Cst. Adam Merchant, and Cst. Aaron Patton, the first three RCMP officers who arrived on the scene in Portapique on April 18, 2020, would be called as witnesses to testify in late March 2022. They would provide testimony together as part of a witness panel.
- Several senior RCMP officers involved in making command decisions – S/Sgt. Stephen (Steve) Halliday, S/Sgt. Addie MacCallum, S/Sgt. Brian Rehill, and S/Sgt. Jeffrey (Jeff) West as well as Sgt. Andrew (Andy) O'Brien – would be called as witnesses in late May 2022, after the Commission had presented more of our Foundational Documents, including one focused on RCMP command decisions. This timing ensured that the best-informed questions could be asked of these officers.
- In addition to the witnesses proposed by Participants, we advised that we intended to subpoena the following senior RCMP representatives once the factual foundation was established in the spring or summer of 2022: Commr. Brenda Lucki, A/Commr. Lee Bergerman, C/Supt. Chris Leather, and Supt. Darren Campbell.

We informed Participants and the public that all witnesses named in our decision would be called pursuant to a subpoena to provide sworn or affirmed testimony either as individual witnesses or as part of witness panel. We emphasized that it was important to remember that our decision of March 9 was not the final or a complete list of witnesses. The Commission's approach meant that we continued to call new witnesses as needed to provide more clarity about what happened and why, and we continued to hear submissions from Participants about additional witnesses. Whenever possible, each Friday the Commission released a list of witnesses to expect for the coming week of proceedings.

Witness Accommodations

Anyone who was subpoenaed to appear before the Commission as a witness, including civilians and first responders, could apply for "accommodation" – adjustments made to usual processes to ensure that everyone can fully participate. Accommodations were made to the ways a few of the witnesses testified, creating

the conditions to ensure we could hear their evidence in full. Among the ways the Commission accommodated witnesses were taking additional breaks during testimony, approving a support person to accompany a witness, and allowing a witness to provide testimony by video rather than testify in the public hearing room in the physical presence of media, Participants and their counsel, and members of the public. We agreed that, whenever possible, we had a responsibility to get necessary information in ways that caused no additional harm.

The Commission shared the content of all the witness testimony we heard with the public and the media through public proceedings, interview transcripts, summaries of the evidence, and on our website. In almost every case, the Commission webcast the oral testimony of witnesses at the time they gave their evidence in the public proceedings and posted it on our website.

The Commission's approach to how it would receive oral evidence was guided by restorative principles and consistent with its role in an inquisitorial process. Relying on its extensive collection of documents and other materials, including interviews, recordings of radio transmissions, and video evidence, the Commission identified individuals who could help fill a gap, address an inconsistency in the record, or share an insight that was not yet available. Consistent with this approach, the Commission would identify the purpose for which a witness was being called and advise Participants in advance of the focus the questions would take.

In adversarial processes, judges act as neutral adjudicators hearing from witnesses selected by each side of a dispute. They are often unfamiliar with the evidence a witness will provide and are hearing about the issues for the first time in public proceedings. Witnesses in court are often asked to repeat the information they have provided in statements because the statements are not relied on as evidence.

Another way the Commission ensured it was able to get the information it needed from witnesses was to offer flexibility in how it heard from them. Some of these approaches were adopted in consultation with counsel for those who were most affected, freeing them from the need to apply for accommodation. For example, many Participants who were family members of people whose lives had been taken in the mass casualty explained that it would be difficult to share their information in a public proceeding or webcast. The majority of these witnesses provided oral evidence in small group sessions or in Participant consultations that were transcribed.

Other witnesses applied for accommodation under Rule 43 of the Commission's Rules of Practice and Procedure:

> If special arrangements are desired by a witness in order to facilitate their testimony, a request for accommodation shall be made to the Commission sufficiently in advance of the witness' scheduled appearance to reasonably facilitate such requests. While the Commission will make reasonable efforts to accommodate such requests, the Commissioners retain the ultimate discretion as to whether, and to what extent, such requests will be accommodated.[40]

Accommodations were designed to ensure that the Commission received the best information possible from witnesses. Different witnesses required different accommodations. Being trauma-informed does not mean not hearing from a person; it does mean thinking carefully about how to hear from a person and accommodating accordingly.

Because Commission counsel are responsible for ensuring that all issues in the public interest are brought to the attention of the Commissioners, they considered accommodation requests and made recommendations. However, the Commissioners retained the ultimate discretion as to whether witnesses would be accommodated and to what extent. In our process, a witness or counsel for a witness submitted a Rule 43 request in writing, setting out the proposed accommodation and the reason. Commission counsel reviewed the request and the supporting material. If, in their view, the requested accommodation did not prevent the Commission from reliably obtaining the information it needed from the witness, they recommended to the Commissioners that the request be granted. If Commission counsel were of the opposite view, they explored other kinds of accommodation with the witness (or their counsel).

After the Commissioners received the recommendation of Commission counsel, it was shared on a confidential basis with the applicant witness and the Participants. If the Participants were concerned that the recommended accommodation would interfere with the objective of calling the witness, they could raise these concerns in written submissions to the Commission.

One challenge in designing an accommodation process is that such requests are almost always based on witnesses' physical and mental health. Because the Orders in Council required that the Commission not disclose personal information governed by privacy legislation without consent or unless the public interest in the disclosure outweighed any invasion of privacy arising from the disclosure, the Commission had to treat the information it received with Rule 43 applications as confidential. Some Participants who wanted to understand the basis for an

accommodation request were frustrated by this constraint. In some circumstances when a witness consented, the information was shared confidentially with counsel for Participants. In one unfortunate situation, one such counsel shared in an interview with the media the names of two RCMP witnesses who were seeking accommodation. As a result, some applicants under Rule 43 became reluctant to share information with Participant counsel.

Commission counsel received the first accommodation request, relating to six RCMP witnesses, in May 2022, and we released our decision on May 24, 2022 (Appendix I-2). Although we did not grant all accommodation requests, we directed that S/Sgt. Allan (Al) Carroll testify by videoconference (we used the Zoom platform), with breaks as needed, and that Sgt. Andy O'Brien and S/Sgt. Brian Rehill testify by videoconference with Commissioners, Participants, Participant counsel, Commission counsel, and accredited media attending in real time. In our decision, we noted that, given the health information provided to us, allowing the witnesses to provide evidence in this way would reduce the stress and time pressure that arise from giving oral evidence in live proceedings. The video format would facilitate their testimony and provide clear evidence for the Commission. We also recognized that it was important to have outstanding questions put to the witnesses. We invited Participants to provide questions in advance, and we scheduled two meetings during the witness testimony in which Participants, as in caucus meetings during public proceedings, could put forward any additional questions.

S/Sgt. Rehill testified on May 30, and Sgt. O'Brien on May 31, 2022. Commission counsel asked all the questions provided by Participants through their counsel and, at the end of the second virtual caucus, no Participant identified any further questions they wished to be asked. The video recording of the testimony of these two witnesses was posted to our website within 24 hours and was also made an exhibit (though there was a delay because it had to be broken into several videos to upload to Relativity).

Our decision to adopt this process was controversial. Some Participants whose family members' lives were taken in the mass casualty objected and spoke publicly to the media. Some declined to provide questions for the witnesses. In the media, their counsel suggested the accommodations were hindering the ability of the Commission to get to the truth about the mass casualty. Some Participants left the proceedings and set up a small protest outside the venue, with supporters carrying placards. Some Participants voiced their objections to the Commission, but

still fully participated in the proceedings during the testimony of S/Sgt. Rehill and Sgt. O'Brien.

One family Participant applied to have these witnesses recalled for questioning directly by family Participant counsel. A second family Participant, in a submission dated June 9, 2022, asked us to amend the Commission's Rules of Practice and Procedure so that Participant counsel would have the automatic right to question all witnesses directly. We issued a decision on June 17 denying these requests (Appendix I-3). At paragraph 34 of our decision, we wrote:

> The simple reality is that we faced a situation where our ability to obtain the best possible evidence from vulnerable witnesses was at risk. In our estimation, exposing them to cross-examination by various Participant counsel would not have provided the conditions for them to provide comprehensive testimony. The adversarial approach represented an added risk that would have been unwise to take. We calibrated a process whereby these witnesses were able to provide the comprehensive testimony we required, while ensuring that all Participant questions would be addressed.

Over the course of our mandate, out of 60 witnesses, 9 witnesses with wellness concerns or other private issues made requests to the Commission for accommodations to facilitate their testimony. These requests were not automatically granted. The Commissioners decided in each instance whether accommodation was needed and, if so, what it would be. We granted accommodations (though not necessarily what was requested) in response to applications by 6 witnesses. The nature of these accommodations varied from allowing a witness to testify by Zoom to determining that the remaining questions for a witness could be provided by a sworn affidavit.

We ensured that Participant counsel had opportunities to ask questions of the witnesses. In almost every instance, Participant counsel asked questions directly, after deciding among themselves who was best placed to do so. In the case of three witnesses (S/Sgt. Rehill, Sgt. O'Brien, and Ms. Lisa Banfield), only independent Commission counsel asked questions, but Participant counsel had the opportunity to provide their questions both in advance and during breaks in the questioning. With respect to Ms. Banfield, Participant counsel were also invited to provide questions in advance of the five interviews conducted with her by Commission staff.

We released our second and last decision regarding Rule 43 on September 2, 2022, in which we approved a witness's application for accommodation (Appendix I-6). The witness testimony of Cst. Greg Wiley was available for the public to watch, but registration was required to view the proceeding. Members of the public were asked to submit their registration to Commission staff and, once registered, they were sent a link via email to watch the proceeding. We also made the transcript of the witness's appearance available on our website. This accommodation, like all similar decisions, followed an application, with supporting materials, counsel for Cst. Wiley made to the Commission.

Ms. Banfield occupied a unique position in that she was both a fact witness and an individual directly affected as one of the few people who survived an encounter with the perpetrator on April 18 to 19, 2020. Given her situation as a survivor of the perpetrator's violence, as one of those most affected, and in light of the quality and quantity of information she had already provided to the Commission in a series of recorded interviews, we directed that all questions for Ms. Banfield from Participants be asked by Commission counsel. As with S/Sgt. Rehill and Sgt. O'Brien, Participants were invited to provide areas for questioning in advance and at two breaks during her testimony. Because she was a survivor of the violence, like others among those most affected, we did not require Ms. Banfield to make a Rule 43 application.

Witness Outreach

In February 2022, the Commission's public engagement and communications team organized outreach to individuals, not represented by counsel, who were named as witnesses in Phase 1 Foundational Documents to ensure they knew that information they provided would be made publicly available. Information for these documents had been gathered in a number of ways, including site visits by our investigations team, interviews by the Commission, and from documents gathered from institutions such as the RCMP.

The Commission established a process to connect with more than 400 witnesses whose statements to police, the Commission, or both would be made public during the course of proceedings. In an effort to be attentive to the needs of and the impact on those most affected and harmed, we wanted to alert them to the exact portion of their information that would be included in the Foundational Documents. Witness contact information was not always available or current, but we attempted to reach more than 250 witnesses in all.

Each outreach call began by stating the name and role of the caller at the Mass Casualty Commission and asking the witness if it was a convenient time for a conversation. We provided information about both the Commission and the information-gathering and redaction processes, and allowed space for questions. The excerpts and paragraphs where a witness was referenced were often read to the witness, and we offered to email the link to the Foundational Document. In instances where connectivity and internet access were issues, we mailed a copy of the Foundational Document to the witness.

With individuals who had indicated they wished to have minimal contact with the work of the Commission as well as those most affected, we completed our outreach by sending mailed letters to the residence, stating that the Foundational Documents that included their names and information would soon be made public. Letters were sent using Mass Casualty Commission letterhead and envelopes so that those receiving the letters could decide if and when to open the letters.

Many witnesses interviewed by the RCMP in the aftermath of the mass casualty were not aware that their statements would ever be made public, and more than two years had passed since they had received any information or follow-up support. Many witnesses thanked the Commission for alerting them that materials were about to be published, and those who had concerns were able to speak with Commission counsel before the release of the information. Our witness outreach coordinators had experience in social work and were able to direct witnesses to appropriate services and supports.

Panels, Witness Panels, Witness Circles, and Small Group Sessions

To create the most effective means of establishing a factual foundation and gaining an understanding of the issues in our mandate, the Commission planned to use different ways to hear from people, individually or in groups, during our public proceedings. We planned for and heard from individual witnesses who provided sworn testimony, including representatives of institutions, subject matter experts, and people with technical expertise (technical witnesses) who explained, for instance, how particular systems work.

Early in our public proceedings, we held panel discussions on mental health and rural communities to ground the public in the materials to come. While the opening panels were focused and key questions were developed collaboratively, the panels were not scripted. Instead, we invited a cross-section of representatives to

A panel about life in rural Nova Scotia taking place during public proceedings of the Mass Casualty Commission. From left to right: Commissioner Kim Stanton, Commissioner Michael MacDonald, and Commissioner Leanne Fitch, Chief Sidney Peters, Mary Teed, Rev. Nicole Uzans, Dr. Ernest Korankye, and Alana Hirtle.

share their voices and perspectives. As our proceedings progressed, we heard from many more people to provide context and share experiences. These conversations were key to the Commission's mandate and to our commitment to ensure that the human impact of the mass casualty received proper attention. **The Commission took the approach that it is important to begin by contextualizing what happened within larger conversations about the context and impact of the events.**

We also heard from witnesses in panels where two or more witnesses were questioned concurrently. Panels are commonly used in public inquiries as a way to draw out facts and experiences of a group of people who shared a common experience. For example, when the Commission presented its Foundational Documents about the events at the Onslow Belmont Fire Brigade hall and in Shubenacadie on April 19, 2020, we also hosted a panel that included three witnesses who were present at the hall on April 19, 2020. Similarly, when the Commission presented our Foundational Document about the death of the perpetrator, we convened a panel of the two RCMP members who recognized and shot him at the Enfield Big Stop on April 19, 2020.

We found that by placing witnesses on the same panel, they could supplement one another's responses in real time and thereby improve our understanding of the evidence. This format also saved time by allowing us to question witnesses concurrently. It worked particularly well for expert witness panels – for example, when Dr. Kristy Martire and Dr. Tess Neal spoke about their expert report "Rigorous Forensic Psychological Assessment Practices (Part I and II)" on July 22, 2022.

We had initially planned to hear from some witnesses in a "circle" format. This is a discussion-based format that is used not to determine facts but to provide important context to understand what happened. The facilitator of a circle does not ask direct questions as you would of a witness in a trial, because a circle builds instead on a shared understanding of a set of facts. A witness circle is not a chance to test evidence. Rather, during witness circles, the facilitator uses a dialogue-based format to gather additional insight to help the listener understand the underlying facts. An understanding of the human aspect of institutional and organizational systems under scrutiny makes it more likely that the listener can make recommendations that will be practical for the people who work in the systems.

Our initial plan had been to hear from the three RCMP members who responded to the initial 911 call to Portapique on the night of April 18, 2020, in a way that would bring their full experience to light in the least traumatizing way for them and for all listeners. In our view, the facts were clearly laid out in the radio transcripts and their previous statements, and we felt we could best elicit their experiences that night if they were given the opportunity to speak together in a witness circle. However, that well-intentioned plan created such backlash from some Participants and their counsel that we feared the information gleaned from these first responders would be lost in the fray over the process. At that juncture, we therefore decided to hear from the three first responders together as a witness panel instead of a witness circle.

A few months later, in Phase 2 proceedings in June 2022, we heard from other first responders (including paramedics who attended at Portapique on April 18, 2020) in a series of small group sessions, described in more detail below. In these public, facilitated sessions, we heard directly from people with first-hand and related experiences, helping us to better understand the impact of the mass casualty. We did not doubt the veracity of what they told us: they were genuine and forthright, and we think they told us more in this format than they would have under the stress of the adversarial process.

> Inquiries have a large scope to develop facilitated processes that elicit experience-based information from witnesses. Experience-based information helps contribute to the understanding of what took place and ultimately to formulating useful recommendations.

Participant Submissions

The Commission invited Participants to make written and oral submissions throughout our mandate. We created various opportunities for oral submissions for different purposes during each phase of our work as well as at the close of our public proceedings. We also welcomed written submissions from Participants on issues within the Commission's mandate at any time before the deadline for closing submissions. We encouraged Participants to craft submissions that were constructive, focused, and concise.

During our Phase 1 public proceedings, for example, we received written Participant submissions supporting the release of the Enfield Big Stop videos, regarding Participant requests to question witnesses directly, and about Rule 43 accommodations for witnesses.[41] These submissions made a crucial contribution to our assessment and decision-making on each of these important issues.

In addition to the extensive consultation with Participants over several months to have their input on further routes of investigation and to ensure the accuracy of the draft Foundational Documents, the Commission also set aside time throughout our Phase 1 public proceedings to hear oral submissions from Participants regarding any remaining gaps in the factual record related to the Foundational Documents, including witnesses they suggested the Commission should hear. We also invited Participants to offer substantive feedback by July 8, 2022, in writing, on the evidence entered into the Commission's record in Phase 1 (including the first 12 location-based Foundational Documents and related source materials, as well as the information heard from witnesses between February 22 and July 8, 2022). We informed them that we were particularly interested in receiving submissions that identified perceived errors or gaps, added related context, and addressed any "how and why" questions that arose within the factual record established in Phase 1. We requested that Participants provide specific, detailed submissions on the content of the individual Foundational Documents to the Commissioners in writing,

to ensure we captured this feedback accurately. In addition to these ongoing and end-of-phase written submission opportunities, we gave Participants a further opportunity to make submissions related to Phase 1 during closing oral submissions in September 2022. As with all Participant oral submissions, these were available to the public on the webcast and the website. A list of all written Participant submissions is found in Appendix O.

Phase 2: Examining Causes, Context, and Circumstances

In Phase 2, the Mass Casualty Commission built on what we had learned about what happened on April 18 and 19, 2020, and extended that knowledge by seeking answers to how and why the mass casualty happened. Here, the focus was on exploring more deeply the causes, context, and circumstances of the mass casualty as well as related issues as directed in our Orders in Council.

The steps we took to fulfill the mandate in Phase 2 included the preparation of Foundational Documents, the establishment of the Research Advisory Board, the environmental scan of relevant past reports, and the commissioning of technical and expert reports. Many of these steps had been initiated by the summer of 2021, although many of the fruits of this work took a year to prepare and share in proceedings. We also developed a list of the issues to be explored in the Phase 2 public proceedings (see Appendix P), but the major framing of our Phase 2 work flowed from our identification of three pillars or themes in which we could explore all aspects of our mandate.

Activities, Purpose, and Approach

In Phase 2, we built on the Phase 1 location-based factual record and moved to public proceedings that were organized thematically and based on issues identified in the Commission's mandate, such as police paraphernalia, firearms, and public alerting. Many of these topics blended the *what* happened with *how* it came to happen. Thus, as the hearing process that was central in Phase 1 continued (as we

heard from other witnesses, including those involved in command decisions), we also began to hear from people in equally important ways through presentations, roundtables, and small group sessions.

Phase 2 public proceedings included the presentation of topic-based Foundational Documents, related source materials, and other documents, such as investigations supplementary reports and interview transcripts, as well as testimony from a range of witnesses, both individually and in panels. Research reports commissioned on issues within our mandate became an important focus in these proceedings. The reports served as resource material to gain a broader understanding of the wide-ranging issues in our mandate. Some of the authors of commissioned reports appeared as witnesses, some participated in Phase 2 roundtables, and some of the reports were simply introduced at proceedings. Regardless, Participants had an opportunity to make submissions about the reports to assist our understanding of the issues.

We issued a Notice to Participants to prepare them for different activities, including their oral and written submissions, we would be incorporating into the proceedings (included in Annex A). The Phase 2 public proceedings continued to build the factual foundation while also expanding into a broader exploration of how and why the mass casualty occurred. The Commission heard from people with experience, knowledge, and expertise in specific issues to help us to understand the causes, context, and circumstances of the mass casualty. Participants in Phase 2 began to engage directly in the proceedings according to their interest in the mandate, including in sessions aimed at developing a deeper understanding of the issues arising from the mass casualty.

Foundational Documents

The Commission developed a set of Foundational Documents related to our Phase 2 examination of how and why the mass casualty occurred. Members of the research and policy, investigations, and Commission counsel teams conducted interviews and reviewed and analyzed documents. We issued additional subpoenas such as demands for institutional records and for certain policies and training manuals from various institutions, including the RCMP, given that police training and policies were specifically mentioned in our Orders in Council. The research and policy team also identified relevant information already in the public domain, such as government policies that applied to elements of the mass casualty.

The Foundational Documents for Phase 2 addressed the need to examine events relevant to the mass casualty both before and after April 18 and 19, 2020. They included earlier facts such as the perpetrator's past activities and interactions with institutions and the community as well as post-event issues such as next of kin notifications and support services offered to those most affected after the mass casualty.

Foundational Documents – Phase 2

- Information-Seeking from Families, and Next of Kin Notifications
- Support Services for Survivors, Families, and Communities
- Violence in the Perpetrator's Family of Origin
- Perpetrator's Violent Behaviour Toward Others
- Perpetrator's Violence Toward His Common Law Spouse
- Perpetrator's Financial Misdealings

Because these Foundational Documents were being prepared concurrently with our public proceedings, we did not hold working meetings to receive feedback, but requested written feedback asking the same questions we had posed in the working meetings. The feedback was very helpful and assisted the Commission in ensuring the documents' accuracy and in identifying areas for further investigation. Some of the documents focused on the experiences of a few of the Participants (e.g., the "Support Services for Survivors, Families, and Communities" Foundational Document and the "Information-Seeking from Families, and Next of Kin Notifications" Foundational Document), so it was important to receive their feedback before the documents were shared publicly in proceedings.

Roundtables

Phase 2 marked the start of the Commission's roundtable discussions. Over the course of our mandate, the Commission held 21 roundtables that brought together experts, Participant representatives, and community members with expertise who provided their insights on relevant issues through public, facilitated discussions.

Roundtables provided critical opportunities for us to learn more about issues related to how and why various aspects of the mass casualty happened. A complete list of our roundtables is found in Appendix Q. Annex A includes further detailed documents for each.

Roundtables have been used effectively in many other Canadian public inquiries, such as the Inquiry into Pediatric Forensic Pathology in Ontario,[42] the BC Missing Women's Inquiry (where they were referred to as "forums"),[43] and the Public Inquiry Respecting Ground Search and Rescue for Lost and Missing Persons in Newfoundland.[44] Countries across the world also use this type of approach focused on gathering insights and context to inform recommendations – for example, the Royal Commission into Institutional Responses to Child Sexual Abuse in Australia.[45]

Our roundtables did not discuss facts specific to the mass casualty, such as particular police decisions, facts about the perpetrator and his actions, or other parts of the factual record. We asked roundtable members *not* to comment on the evidence entered in Phase 1 or Phase 2 proceedings, or to express views on what happened on April 18 and 19, 2020. Rather, we requested them to provide the necessary context and expert discussion to assist us with interpreting the factual record.

Some Participant counsel objected that they were not able to question members of the roundtables directly. However, Participants were invited to suggest members for the roundtables planned on issues related to their area of substantial and direct interest. We considered these submissions carefully and adopted many of them, though we ultimately directed the composition of roundtables to ensure that we received balanced and diverse perspectives on the issues they addressed. The facilitated discussion that ensued at roundtables provided a great deal of valuable information to the Commission that may not have been possible if each member had been directly questioned by multiple Participants based on their interest.

We attended the roundtables, asked questions, and found them incredibly helpful in illuminating the complexities of the issues in our mandate. For each roundtable, the Commission's research and policy team prepared a bundle of supporting documents, including, for example, expert reports, legislative and policy briefs, and academic articles. We marked evidentiary material contained in the bundle as exhibits.

> Hearing from people with years of experience and deep expertise in the areas in which we were required to make recommendations cautioned us not to make assumptions about easy solutions and helped us to understand the ramifications of some of the proposed solutions. For example, the public-alerting roundtable explored various potential models and the implications of adopting one or another not just from a technical perspective but also from the perspective of considerations in a rural as opposed to an urban setting.

The roundtables drew on the excellent expert reports, allowing us to gain a better understanding of areas about which we did not ourselves necessarily have expertise from people who had considerable knowledge about the issues in our mandate – for example, public alerting, critical incident decision-making, gender-based violence, and policing accountability and oversight.

Small Group Sessions

In the Phase 2 proceedings in June 2022, the Commission hosted the initial small group sessions. These sessions were designed to foster dialogue that would deepen our understanding of the context and impact of the mass casualty. The first set of sessions brought together individuals to discuss their experiences with regard to information sharing during the mass casualty and in the immediate aftermath as well as the support they received after it happened.

In the first session, the Commission heard from Emergency Health Services (EHS) first responders, including paramedics and an emergency dispatcher, who described their perspectives of the response on April 18 and 19, 2020. In another session we heard from Operational Communications Centre (OCC) first responders, who related their experiences and some of the challenges of 911 call-taking and dispatch during the mass casualty as well as the lasting effects of this work. We also listened to other service providers, including the director of the Nova Scotia Department of Justice Victim Services, a forensic nurse from the Medical Examiner Service, and a funeral home director, about their experiences with the provision of services and engagement with families and affected communities after the mass casualty.

In our fourth small group session, we heard from two local elected officials from Colchester County, one of the three counties where the mass casualty took place. These individuals had assisted their constituents, including family members, in the aftermath of the mass casualty. Each session provided valuable information and perspectives that contributed to the Commission's forward-focused mandate to make recommendations that could help prevent and respond to such incidents in the future. In our Phase 3 proceedings, we arranged for additional small group sessions.

As we explained in the Notice to Participants, the purpose of roundtables and small group sessions was not to garner specific evidence about the facts of the mass casualty but to provide the Commission with the opportunity to access a broader range of experience-based and expert knowledge. These forms of knowledge are best shared and explored through facilitated dialogue. The Phase 2 activities were intended to be non-adversarial opportunities for the Commissioners to hear directly from people, including, where appropriate, the Participants themselves. Accordingly, members of the sessions were not sworn. As with all public proceedings, the roundtables and small group sessions were held in the presence of Commissioners and formed part of the public record. They were held in public and webcast, with transcripts posted on the website. We also advised that roundtables and small group sessions would be led primarily by members of the Commission's research and policy team and the public engagement and communications team. Commission counsel would continue to focus on other aspects of the proceedings.

Participant Submissions

As in Phase 1, Participants had the opportunity to provide written submissions to the Commission during Phase 2 of our public proceedings, according to their interest and in keeping with the parameters of their contribution agreements and their funding.

We also invited Participants to provide written and oral submissions on specific issues covered in the Phase 2 public proceedings as they arose and in a cumulative manner at the end of Phase 2. In practice, we arranged opportunities for Participants to provide oral submissions on:

- access to and regulation of police uniforms, equipment, and vehicles;
- access to firearms – enforcement, smuggling, and regulatory approaches;

- emergency alerting;
- Foundational Documents presented in Phase 2;
- critical incident planning, preparation, response, and decision-making;
- emergency communications (within the RCMP and among responding agencies), interoperability among agencies, and police and government work after the mass casualty, including communications with those most affected;
- understanding and addressing the immediate and long-term needs of those affected by mass casualty incidents;
- rural community safety and policing, and rural policy and resources;
- mass casualties: psychology, psychiatry, and sociology;
- mass casualties, intimate partner violence, gender-based violence, and family violence; and
- police and institutional understanding and responses.

The purpose of these submissions was to continue to build on the factual foundation while also expanding into a broader exploration of how and why the mass casualty occurred. We informed Participants that we were particularly interested in hearing about any gaps in evidence and information gathered in Phase 2 to enable us to consider whether additional steps had to be undertaken. For example, if a Participant identified a gap or error in a Foundational Document presented in Phase 2 or wanted to provide additional context, we welcomed submissions, where possible, at the earliest opportunity following the presentation. Similarly, the Commission encouraged Participants to provide additional information and submissions related to topics addressed in roundtables or small group sessions in Phase 2. Participants' written submissions for Phase 2 were due on September 2, 2022.

One example of the way Participant submissions assisted the Commission was a request by counsel for the Goulet family, Jane Lenehan, who sought more information about changes being made within the RCMP after the mass casualty. The Commission issued a subpoena to the RCMP to provide this information as part of our forward-focused approach to making recommendations and our desire to learn about changes to policies and procedures in progress within governments and institutions across Canada since the mass casualty (see also the environmental scan that the Commission conducted of past recommendations).

Three Pillars: Policing, Community, and Violence

An integral part of the Commission's mandate was to understand the causes, context, and circumstances of the mass casualty. In designing our work, we established certain themes that would bring together related questions and issues, as enumerated in the Orders in Council. The three overarching themes, or pillars, provided a framework to help guide our work: policing, community, and violence. This thematic approach assisted us in connecting the dots among specific facts, incidents, issues, contexts, causes, and consequences.

From this starting point, we identified a range of sub-issues arising from our initial investigations and from the information gathering that continued throughout Phase 1, and we added other issues and perspectives as we explored these themes in depth throughout Phase 2. This thematic framework, established in the spring of 2021, guided us as we developed topic-based (as opposed to location-based) Foundational Documents, commissioned technical and expert reports, and established our Research Advisory Board. It also assisted us in carrying out an environmental scan of past reports relevant to our mandate and in identifying additional areas for research and analysis. The Phase 2 Foundational Documents and expert reports provided a significant further layer of contextual information, adding to the evidentiary foundation we developed through our Phase 1 activities.

Collaboration was essential in the design of our work. To facilitate the Commission teams as they worked in integrated rather than fragmented ways or silos to tackle key topics, we established "pods": cross-disciplinary internal working groups that included members of the investigations, counsel, and research and policy teams. We structured each pod around one of the sub-issues: critical incident response and the police context (including oversight, accountability, and management); firearms; police paraphernalia; intimate partner violence / gender-based violence; rural communities; and post-event support.

Policing

Three cross-disciplinary pods carried out the Commission's work on policing: police paraphernalia, critical incident response, and the context of police work. Several of the expert reports we commissioned were relevant to both critical

incident response and the police context, and we discuss them in relation to the pod most relevant to them.

During the first few days of public proceedings, the Commission placed the information contained in our location-based Foundational Documents in context. For example, the Commission presented the technical report described above by Barry MacKnight about "The Structure of Policing in Nova Scotia" to explain the structure of police services and to share some key information about the responsibilities of police services, their jurisdictions, and the resources available to them in the province. We also heard from a technical witness, Darryl Macdonald, who provided an understanding of 911 call-taking and dispatch operations that was relevant to understanding three Foundational Documents about the early hours of the mass casualty. In addition, we heard from three RCMP officers who were the first to arrive on the scene in Portapique on April 18.

Together, the report on the structure of policing and the technical witness established a practical basis on which to hear the information that ensued in public proceedings about the involvement of a variety of police agencies and the importance of the radio communications during the mass casualty.

Police Paraphernalia

The police paraphernalia pod investigated questions such as how the perpetrator acquired the uniform and vehicle used during the mass casualty and who assisted him and/or knew he had this paraphernalia. It also examined how the perpetrator's disguise assisted him to commit his crimes and what impact that had on the response during the mass casualty. This evidence was summarized in a Foundational Document that described the perpetrator's access to and use of police vehicles and associated equipment, kit, and clothing. The broader issues addressed by this pod included the regulation, procurement, access, and disposal of police paraphernalia; the scale and nature of the problem of police impersonation in Canada; and the effect of police impersonation on the community's trust in police. The Commission prepared a legislative brief on police impersonation and paraphernalia, which provided information about the applicable laws in Canada at the time of the mass casualty in April 2020. This document assisted the Commission in fulfilling its mandate by providing factual information about the rules in place at the time.

The topic of police paraphernalia illustrates the way Phase 1 began to merge with Phase 2 as the Commission's proceedings progressed. When the Commission shared two topic-based Foundational Documents related to policing – one about police paraphernalia, and the other about the confirmation of the perpetrator's replica RCMP cruiser – the Commission supplemented the information contained in these documents on what happened during the mass casualty with information on how and why it happened. For example, during a presentation in the public proceedings about the life cycle of police uniforms, equipment, and vehicles, we heard testimony from a witness who was employed at GCSurplus at the time of the mass casualty. He described his dealings with the perpetrator, who had purchased some items, including the vehicle used during the mass casualty, from GCSurplus. We also heard submissions from Participants who wished to provide the Commission with substantive input about access to and regulation of police uniforms, equipment, and vehicles.

To further build on the information contained in the Foundational Documents about police paraphernalia and the perpetrator's replica RCMP cruiser, the Commission convened the first of 21 roundtable discussions, "Police Paraphernalia and Police Impersonators." This roundtable addressed the cultural significance of police uniforms and equipment and the role that symbols of policing play in public and community relationships with police, including the perspectives of collectors of police paraphernalia. It specifically considered the cultural significance of police uniforms and equipment for police, and explored the personal possession of police equipment by police, including retired police. Finally, it tackled the problem of police imposters, including the number and nature of police impersonation cases that have arisen in Canada, and the impacts of police impersonation on public trust in police.

Throughout the Inquiry, the media reported incidents of police cars and equipment being stolen. At one point, Nova Scotia introduced legislation to make it more difficult for someone to obtain items to impersonate a police officer (*Police Identity Management Act*).[46] Creating the space and time for this discussion allowed us to better understand the broader context of our work, including topics such as the uses of police paraphernalia beyond policing, the scale of the problem of police imposters in Canada, and the benefits and shortcomings of various approaches to regulating private access to police paraphernalia. The depth and range of information that we heard informed our recommendations in this Final Report.

Our environmental scan revealed that no previous reviews in Canada or in other countries had considered the problem of police impersonation or the regulation of police equipment and clothing, and few experts have studied this issue. The perpetrator of the 2011 mass casualty on Utøya island, Norway, also posed as a police officer, and two of our expert reports address the impact of that aspect of the incident: "Survivors and the Aftermath of the Terrorist Attack on Utøya Island, Norway," by Dr. Grete Dyb, Dr. Kristin Alve Glad, Ingebjørg Lingaas, and Dr. Synne Øien Stensland,[47] and "Police and First-Responder Decision-Making During Mass Casualty Events," by Dr. Bjørn Ivar Kruke.[48] In addition, the expert report by Dr. Bethan Loftus, "Police Culture: Origins, Features, and Reform,"[49] addresses the cultural significance of police symbols to some extent. An academic scan showed no relevant published Canadian research, so the Commission's research and policy team conducted research to fill this gap. They worked to identify and summarize other Canadian incidents of police impersonation and the responses to those incidents. Their "Police Impersonation Case Summary" compiling the results of this research was marked as an exhibit.

Critical Incident Response

Emergency services use the term "critical incident" to describe a life-threatening situation in which immediate responses are necessary even though information about the nature of the incident may be incomplete. In their expert report, "Critical Incident Decision Making: Challenges of Managing Unique and High-Consequence Events," Dr. Laurence Alison and Dr. Neil Shortland state:

> We define critical incidents as events in which demands exceed resources, where there is high uncertainty, dynamic and fast-moving goals, and high stakes. Critical incident decision-making (CIDM) is highly complex because many critical incidents have no analogue, and thus there is no direct prior experience for decision-makers to draw upon.[50]

The critical incident response pod gathered and analyzed information about the issues that arose from the response to the mass casualty. The location-based Foundational Documents recorded the responses at each location, but by design they did not address other aspects of the critical response. Our topic-based Foundational Documents looked at individual elements of the critical incident response, including:

- Truro Police Service;
- RCMP Emergency Response Team;
- air support;
- RCMP public communications during and after the mass casualty;
- RCMP command post, Operational Communications Centre, and command decisions;
- Halifax Regional Police and Halifax district RCMP operations;
- overview of radio communications system in Nova Scotia; and
- overview of 911 call-taking and dispatch in Nova Scotia.

We commissioned several reports related to critical incident response. In "Communications Interoperability and the Alert Ready System,"[51] Chris Davis, Cheryl McNeil, and Peter Gamble provided a technical report on emergency alerting and communications interoperability during critical incidents. This technical report explained the Canadian Communications Interoperability Continuum and its Alert Ready system as it has been designed and implemented. Specifically, the report described what communications interoperability means, how efforts to pursue communications interoperability are governed, and how interoperability systems are designed in Canada. It also described the Alert Ready program, explaining how it works and how it is governed and designed as well as its capabilities and limitations. In addition, the Commission received expert evidence about best practices and useful models for emergency communications from other countries. As our Phase 1 factual record demonstrates, interoperability and public communications are both integral to critical incident response.

Two expert reports provided overviews of research, policy, and practice with respect to decision-making in critical incident responses. Alison and Shortland described the psychological dimensions of critical incident decision-making. They also considered the role of training and preparation for critical incident decision-making, the impact of stress, and common cognitive challenges critical incident decision-makers face. A report by Dr. Bjørn Ivar Kruke, "Police and First-Responder Decision-Making During Mass Casualty Events," provided an overview of the author's research on decision-making in conditions of threat and uncertainty. Based on research and lessons learned, it considered police and first-responder decision-making during mass casualty events, including what happened at Utøya in 2011 and the subsequent review of police responses to this and other such events. The report also addressed the challenges of preparing police and first responders

for mass casualty events, the community and policing resources drawn on in a crisis response, and the role played by civilians within critical incident response.

We also commissioned an expert report by Dr. Curt Taylor Griffiths, "Interagency Communications, Cooperation and Interoperability Within Police Services and Between Police Services and Other Emergency Services: A Review,"[52] which discussed interoperability and critical response in Canada. It addressed the interoperability continuum, the role of interpersonal relationships and trust in interoperability, barriers to interoperability, elements of an effective multi-agency response, and lessons from past Canadian reviews. It also provided case studies from other jurisdictions, particularly best practices drawn from the United Kingdom.

The Commission prepared and presented several Foundational Documents related to critical incident response, along with supplementary material such as our expert and technical reports, witness testimony, and roundtables. During the integration of Phase 1 and Phase 2, it became apparent that we needed to call further witnesses to address gaps in both the location-based and topic-based Foundational Documents. For example, the Commission presented our Foundational Document about the RCMP Emergency Response Team (ERT) alongside a witness panel consisting of responding RCMP members Cpl. Tim Mills and Cpl. Trent Milton, who addressed the actions, observations, and situational awareness of ERT members on April 18 and 19, 2020.

To provide important context and fill in any material gaps relating to the mass casualty, we hosted a witness panel during the Phase 2 public proceedings with Cst. Terence (Terry) Brown and Cst. Dave Melanson, two RCMP members who discharged their carbine rifles at the Onslow Belmont Fire Brigade hall on April 19, 2020. We also heard from RCMP member Cst. Ian Fahie, who provided important context and spoke to material gaps relating to his attendance at Plains Road on the morning of April 19, and his initial observations of the perpetrator's replica police vehicle, also on the morning of April 19, including the presence of the push bar. In addition, we heard from another first responder, Cpl. Duane Ivany, about his attendance to Heather O'Brien, who was shot by the perpetrator on Plains Road on April 19, and his encounter with Lisa Banfield that same morning. This information supplemented earlier witness testimony provided by Dr. Matthew Bowes, the chief medical examiner for Nova Scotia, who spoke about the medical examiner's reports for Heather O'Brien, as well as the medical examiner's report for the perpetrator.

The Commission presented a Foundational Document about Nova Scotia's Alert Ready system as well as legislation and regulation regarding public alerting. We heard from several witnesses who added to our understanding of the context and both the policy and the rollout of Alert Ready in the province. Paul Mason, executive director of the Emergency Management Office (EMO), spoke specifically of his role in policy, management, and implementation of Alert Ready in Nova Scotia. Rodney Legge, technical advisor to EMO regarding Alert Ready, described his technical knowledge of the rollout. Expert witness Michael Hallowes, who is an independent strategic advisor to governments on public alerting systems, explained key principles of system design and governance with respect to public alert systems. He set out the key principles of interagency collaboration and interoperability in effective emergency and critical incident response, including with respect to public communications and education. Mr. Hallowes also described how Alert Ready compares with best practices and principles, and provided examples of the successful application of the principles within other systems. We also heard from RCMP EMS emergency planning coordinator Glenn Mason and Supt. Dustine Rodier, who discussed RCMP awareness of the Alert Ready system and the events relating to public alerting during the mass casualty.

After listening to those witnesses, we invited Participant submissions on emergency alerting. We also convened two roundtables on public communications during emergency events, including emergency alerting. These roundtables considered the design, implementation, and proper use of public warning systems, including considerations for accessibility and equality.

The first roundtable focused on "Systems Design and Implementation." It addressed core themes such as system design principles, including stakeholder engagement for public alerting systems; governance and operation of public alert systems, including questions of access to that system and appropriate use of the system; and the role of training and public education in designing and implementing effective public warning systems.

The second roundtable focused on "Planning for Accessibility and Equality" and discussed matters of accessibility and equality with respect to the design and use of public warning systems. The discussion considered how best to plan and implement public warning systems in a way that addresses differences in access to cellphones and wireless coverage in remote regions and across the Canadian population. It tackled the need to ensure that warnings are communicated in both official languages and in other languages appropriate to the intended audience,

and that they are culturally appropriate for their intended audience. Finally, it considered how to ensure that the use of public warning systems does not reinforce patterns of stigmatization and marginalization – for example, with respect to racialized communities.

The Commission also presented a Foundational Document about the RCMP command post, the Operational Communications Centre (OCC), and command decisions. We heard from several senior RCMP members involved in making RCMP command decisions on April 18 and 19, 2020, about these topics, including S/Sgt. Jeff West and S/Sgt. Kevin Surette, who were the on-call critical incident commanders during the mass casualty. We also heard from S/Sgt. Steve Halliday, acting operations officer for Northeast Nova District; S/Sgt. Addie MacCallum, district advisory non-commissioned officer for Northeast Nova District; S/Sgt. Bruce Briers, RCMP risk manager; and S/Sgt. Al Carroll, district commander for Colchester County. We called these witnesses to address factual gaps in the evidentiary record and to provide important context. They spoke about their roles on those two days, as well as information about decision-making in areas including containment, scene management, and use of resources; the organization of the command post and at-scene command posts; communications within the RCMP and with outside agencies; interoperability with other first responding agencies; policies, training, and preparation for, and reviews of, critical incidents; and the supervision and oversight of RCMP members under their command.

Two other senior RCMP officers, S/Sgt. Brian Rehill, risk manager, and Sgt. Andy O'Brien, were called as witnesses to speak about the command post, the OCC, and command decisions. They provided information about the role of the risk manager and interactions with other command members, as well as the roles and responsibilities of those present at the command post and at the OCC. They described containment efforts in and around Portapique on April 18, 2020; decision-making regarding the initial response to complaint(s) from Portapique; information assessment, dispersal, and communication; and evacuation and air support. They also shared their knowledge of the communications and actions undertaken by RCMP command personnel on April 18 and 19; communications with the Immediate Action Rapid Deployment members via radio; communications and actions flowing from information obtained from witnesses; communications, decisions, and actions pertaining to public communications; and actions, directions, and communications relating to crime scenes, containment, and canvassing in Portapique on April 19. We heard related witness testimony from Debra Thibeault, a resident of

Portapique and a Participant in our proceedings, who provided information relevant to the RCMP's containment efforts in Portapique on April 18.

The Commission prepared and presented Foundational Documents about RCMP public communications during and after the mass casualty. We heard from RCMP public information officer Cpl. Jennifer Clarke to provide insight relating to communications with the public about the perpetrator's replica cruiser during the mass casualty, including the delay in releasing the photograph of the replica cruiser.

We heard from Lia Scanlan, RCMP H Division director of strategic communications, to provide context as to why the RCMP used Twitter and Facebook as primary methods of communication with the public at the time of the mass casualty. We asked her to explain the processes and policies related to the RCMP's public communications, including how tweets are drafted and authorized, as well as to discuss specifics about the RCMP's public communications issued on April 18 and 19, 2020.

The Commission facilitated four roundtables to build on the Foundational Documents and witness testimony related to critical incident response. Those roundtables provided an opportunity to hear directly from people with knowledge and experience relating to critical incident training, preparation, and response. We heard from first responders, experts, and academics who offered lessons from critical incidents and casualties in Canada and beyond. As stated in our Orders in Council, we were required to examine issues related to the mass casualty including police actions, policies, procedures, and training in respect to active shooter incidents. In order to make pragmatic and meaningful recommendations, we needed to gather information about best practices and lessons learned in our community and around the world with regard to the response to mass casualties.

The first roundtable, "Critical Incident Preparedness," addressed core themes such as planning for critical incident response, including emergency preparedness, coordination, and resources; the role of organizational learning and adaptation; and lessons from past reviews of critical incident responses. Notably, this roundtable included Dr. Hunter Martaindale, director of research for the ALERRT Center at Texas State University. He was able to share a wealth of experience and expertise, most recently from the work he and his colleagues were then engaged in to evaluate the police response to the May 24, 2022, mass shooting at Robb Elementary School in Uvalde County, Texas.

The second roundtable, "Critical Incident Response: Civilians, 911, and First Responders," covered a number of different themes, including civilians as first

responders and key informants during a mass casualty incident; the role of 911 call-takers and dispatch in a mass casualty incident; and general duty police members: training and techniques for immediate response to mass casualties.

The third roundtable, "Critical Incident Decision-Making Including Stress Management," encouraged discussion of common psychological factors in critical incident decision-making; training critical incident decision-makers; and the psychological and physiological impact of stress on the performance of first responders and critical incident decision-makers.

In the fourth roundtable, "Contextualizing Critical Incident Response: Risks and Trade-offs," members addressed the risk that increasing the focus on critical incident training and preparedness will have unintended consequences. They considered strategies by which this risk could be addressed or mitigated. They offered suggestions on the way that competing priorities for emergency services training and resources should be resolved and considered the role of civil society in decisions about police training and resource allocation.

In addition to the four roundtables noted above, the Commission considered how police services and service providers in Nova Scotia respond to a critical incident. This topic included understanding how they communicate with each other and the public as well as their access to resources such as air support and radio communications. We heard from RCMP and civilian witnesses who provided information on decisions made during the mass casualty. We shared Foundational Documents focusing on municipal police services, public communications, air support, radio communications, and 911 call-taking and dispatch.

As part of this work, the Commission presented our Foundational Document on the Truro Police Service (TPS). We called Chief Dave MacNeil as a witness to provide context for TPS operations during the mass casualty, explain his role as a municipal police chief, and speak to the relationships between the TPS and the Nova Scotia Department of Justice, the Nova Scotia Chiefs of Police, and the RCMP as the provincial police service.

The Commission heard from Halifax Regional Police Chief Dan Kinsella on August 25, 2022. Previously, he had declined all requests for interviews, as did several other members of his force, including senior officers. In response to two subpoenas for written evidence, Chief Kinsella provided answers to 95 questions. The Commission subsequently subpoenaed him to give oral evidence to expand on his answers on topics including municipal policing, policing standards in Nova Scotia,

the integrated policing model in the Halifax Regional Municipality, and interoperability between police forces.

The Commission's environmental scan identified seven reviews that addressed issues related to communications among law enforcement agencies and between law enforcement agencies and the community, with a focus on contemporaneous communications with the community and emergency alerting. None of these reviews were prepared in the context of critical incident response; rather, they were mainly undertaken in response to serial crimes carried out over longer periods of time. Nevertheless, we can draw lessons from the recommendations made, including those on community engagement in the design of alerting systems. In addition, the international scan provides useful insights into these issues.

The Commission prepared a legislative brief that provided the law applicable to the National Public Alerting System (Alert Ready). Although this system was not used during the mass casualty in April 2020, an understanding of it is important to the work of the Commission.

Police Context

The police context pod gathered information to help us understand both senior command decision-making during the response to the mass casualty and RCMP operations in the days and weeks that followed. The pod also assisted us to understand the influence of police culture and the known contextual factors that preceded and influenced the mass casualty response. These factors included the following points:

- decision-making around the use and deployment of police resources in Nova Scotia, including financial and human resources, technical assets, and equipment issues and the preparation and management of those resources for daily delivery of police services, including response to a critical event;
- executive-level and strategic decision-making, including supervision within and stewardship of the RCMP and the role of RCMP National Headquarters;
- decision-making around communications:
    - internal communications, including communications between H Division (Nova Scotia) and RCMP National Headquarters;

  - interagency communications and collaboration and, specifically, criminal intelligence sharing with municipal police forces and enforcement and public safety entities; and
- communications with the public, including the role of and relationship with the media; and the role of oversight bodies and the provincial and federal governments, where relevant to the Commission's mandate.

Many of the expert reports commissioned on topics related to critical incident response also contained important insights for the police context theme. We commissioned five additional reports to further our understanding of the issues raised within it. "Culture in Police Organizations: Definitions, Research and Challenges," by Dr. Holly Campeau,[53] provided an overview not only of the literature on policing studies but also of the sociology of culture and organizational culture specifically related to policing. Dr. Campeau suggested that culture is a resource or repertoire of tools that police can draw on in a given situation, rather than being a set list of beliefs or values that determine how a given police officer will act in a given moment. She also explored the differences between the cultural resources front-line members use and those used by police officers who serve in management roles. Finally, Dr. Campeau drew on her own ethnographic research with police officers in Ontario to describe how this understanding of police culture as a resource aids interpretation and understanding of police work.

On the issues of policing and community, we commissioned an expert report on "Community-Engaged Rural Policing: The Case for Reform and Innovation in Rural RCMP Policing" by Cal Corley and Dr. Chris Murphy.[54] This report explored contemporary organizational and operational attempts at police reform and change in the RCMP as well as barriers to implementing reform, with a focus on the response and implementation of community-based policing services at the local, municipal, and rural levels. The report identified relevant community-based and community-engaged models and strategies for delivering policing and public safety services at the local level. It also offered some alternative policing models for responsive and engaged local police services in Nova Scotia.

The report by Dr. Benjamin Goold, "Exercising Judgment: Understanding Police Discretion in Canada,"[55] dealt with discretion and oversight within policing. It examined the scholarly literature on the nature of police discretion, focusing on how the working culture and organization of law enforcement agencies structure the exercise of police discretion and associated powers, such as the powers of arrest, detention, and use of force. In particular, it highlighted some of the key barriers to

making police discretion more transparent, information sharing more routine, and oversight more effective. It identified examples from non-Canadian jurisdictions of best practices and promising approaches to ensuring that the police have meaningful legal oversight and are accountable to the diverse communities they serve.

A report by Dr. Bethan Loftus, "Police Culture: Origins, Features, and Reform," addressed the cultural significance of police uniforms and symbols, both within police culture and to the broader culture. It explained what ethnographic research entails, and summarized findings from ethnographic research with police. Dr. Loftus explained both the core themes that have been identified within the literature about police culture and the literature that argues that police culture is much more nuanced, contested, and subject to change than early studies suggested. The report specifically attended to research addressing differences between rural and urban police cultures, police relationships with non-white communities, and the experiences of police officers who do not embody the implicit norms of police culture. Further, it discussed police culture with respect to intimate partner and gender-based violence, including implicit concepts of deserving and undeserving victims. It addressed internal and external drivers of change in police culture, including the effect of external reviews of police and recommendation or reform approaches that have been more and less successful. This report also incorporated Canadian research and pointed to gaps in this research.

The report by Dr. Anna Souhami, "A Systematic Review of the Research on Rural Policing,"[56] discussed the size and scale of police departments, how they vary across jurisdictions, and tensions between centralization and localization in rural policing. It explored community relationships as well as the challenges of cultivating local knowledge and understanding while avoiding the pitfalls of co-optation. The report also discussed the patterns of exclusion, particularly for Black and Indigenous individuals and other marginalized groups within rural communities, and how police can contribute to these patterns.

We presented Foundational Documents about air support; the Halifax Regional Police and Halifax District RCMP Operations; an overview of 911 call-taking and dispatch in Nova Scotia; and radio communications in the province. The Commission facilitated a witness panel of Trevor MacLeod, director of public safety radio and PTT engineering and operations at Bell Mobility; Matthew Boyle, director of public safety and field communications at the Province of Nova Scotia; Todd Brown, director of strategic initiatives, public safety and field communications at the Province of Nova Scotia; and Christian Gallant, RCMP divisional IMIT officer to

supplement the information in these Foundational Documents by providing an overview of the "trunked mobile radio" (TMR) system in Nova Scotia. We convened a roundtable discussion about how emergency services agencies work together, including emergency communications within the RCMP and among responding agencies, and the related issue of cultivating interoperability among agencies.

After extensive dialogue with the RCMP, the Commission prepared two policy booklets. The first, divided into three parts, set out the national, divisional, and detachment-level policies the RCMP identified to the Commission as those requisite to the Commission's mandate and in force at April 2020 (or as updated since, where indicated). The second, following the same timeline, focused on the policies of H Division (Nova Scotia).

All these materials and proceedings, including the Phase 1 location-based Foundational Documents, the topic-based Foundational Documents, the critical incident decision-making roundtables, and a wealth of other evidence and discussion, laid a solid foundation for our policing pillar. Together, they set out the facts of what happened during the mass casualty and provide considerable insights into how and why it happened. At that point in our proceedings, in July and August 2022, we next heard from several senior RCMP members: Supt. Darren Campbell, C/Supt. Chris Leather, A/Commr. Lee Bergerman, and Commr. Brenda Lucki.

In the last week of July, Supt. Campbell, who served as support services officer for the RCMP in Nova Scotia during the mass casualty, testified for two days. He spoke to his experience and roles; information management during a critical incident; public communications during and after April 18 and 19, 2020; post-event learning; and further context regarding his involvement during the mass casualty. The Commission then heard two days of witness testimony from C/Supt. Leather, who was the criminal operations officer for the RCMP in Nova Scotia at the time of the mass casualty. He discussed his experience and roles; his activities on April 18 and 19; information management during a critical incident; post-event communications; internal and interagency communication after the mass casualty; the establishment and activity of the issues management team; and lessons learned. Both Supt. Campbell and C/Supt. Leather responded to questions from Commission counsel as well as Participant counsel.

The Commission heard from retired A/Commr. Bergerman and Commr. Lucki in late August for two days each. On August 22–23, A/Commr. Bergerman spoke about her role at the time of the mass casualty as well as lessons learned, changes made to date, and opportunities for additional changes and improvements. At the time

of the mass casualty, she was the commanding officer of H Division RCMP in Nova Scotia but had retired by the time of her appearance before the Commission. To supplement her lengthy Commission interview, A/Commr. Bergerman spoke about topics such as RCMP culture, the psychological autopsy of the perpetrator, the issues management team, after-action reviews, H Division leadership and supervision, resources, police advisory boards and local governments, communications with municipalities, and community policing.

On August 23–24, Commr. Lucki provided information during public proceedings to supplement her interview with the Commission. She described her role at the time of the mass casualty, lessons learned, changes and opportunities for improvement, RCMP culture, after-action reviews, H Division leadership and supervision, and the role of communications within the RCMP, among other topics.

The Commission's final witness, RCMP D/Commr. Brian Brennan, testified on September 9, 2022. He addressed a range of topics, including after-action reviews, the H Division issues management team, communications within the RCMP and with the public, and H Division leadership challenges such as the wellness review and summary report.

Building on this wealth of material, the final roundtables for the police context pod took place in Phase 3 proceedings. At the first of these roundtables, we heard from experts on "Contemporary Community Policing, Community Safety and Well-being" and considered the importance of inclusivity and responding to diversity and diverse needs as well as the way police services work with and engage the communities they serve. The core themes of this roundtable included best practices for community policing; necessary considerations for inclusive community policing and community safety that are responsive to diversity and the diverse needs of communities; and police approaches to community safety that are grounded in community engagement and community mobilization.

At the second roundtable, the Commission heard from experts on the "Structure of Policing in Nova Scotia." This discussion considered the history of the structure of policing in Nova Scotia and the strengths and weaknesses of the current structure. After the members canvassed potential approaches for reform or restructuring policing in the province, the Commission invited Participant representatives to join in the conversation.

On September 14, the third and final Phase 3 roundtable addressed several core themes: the two elements of policing oversight – governance and accountability;

the relationships among oversight, supervision, discretion, and the independence of operational decision-making; and effective models of oversight, including the regulation of discretion and ensuring effective oversight while preserving operational independence. Several of the experts who wrote commissioned reports participated in the discussion, along with Michelaine Lahaie, chairperson of the Civilian Review and Complaints Commission for the RCMP, and other experts in policing.

Numerous Nova Scotian and other Canadian reviews have made recommendations with respect to police oversight, training, preparation, and culture. These recommendations and assessments of their implementation provided us with an additional perspective into the police context and identified recurring challenges in achieving reform.

Other work by the police context pod contributed to our understanding of command decision-making during the response to the mass casualty as well as the influence of other contextual factors that did not result in witness testimony. This pod continued working late into the Commission's schedule as team members interviewed and requested documents until the point where they could no longer be included in the public record. For example, they interviewed A/Commr. Dennis Daley, the incoming H Division commanding officer (at the time of his interview he was in the process of transferring to Nova Scotia from his role in contract and Indigenous policing). This interview focused on the mass casualty response, after-action reviews, H Division's issues management team, the Quintet Wellness Report, and priorities for his upcoming role as commanding officer, among other issues.

The police context pod also uncovered information that pertained to a July 2020 referral to the Serious Incident Response Team (SiRT) by the RCMP that involved a municipal police service. This revelation required a second, more focused interview with C/Supt. Leather to clarify how the information came about, what was communicated to SIRT, and what was known about any action SiRT took regarding the allegations. The team also interviewed Felix Cacchione, the former SiRT director, as well as Mark Furey, the former minister of justice in Nova Scotia. In all cases, their transcripts formed part of the Commission's record.

Community

The Commission established three cross-disciplinary pods within the community theme: rural communities, firearms, and post-event support. In addition to the pods' work, the community pillar underscores the ways in which the impact of the mass casualty on communities framed our understanding of the mandate. The Commission actively sought input from communities and the public in order to better understand the broader impact of the mass casualty.

Share Your Experience

The mass casualty had a far-reaching impact within and beyond the communities most affected. As the Commission developed the core evidentiary foundation through witness interviews and document review, it became clear that we required additional mechanisms to seek input about these broader repercussions. Our early public outreach efforts had also shown us that many people were seeking a way to connect with the Commission about what they had encountered during and in the aftermath of the mass casualty and its continuing ramifications. For example, some people used the Commission's general inquiries email address to communicate what they were going through because of the mass casualty. We also heard from many people who were deeply affected by the mass casualty but hesitant to talk about their experience. Several of them explained that they knew other people who had been more directly affected – their friends or neighbours may have lost a family member, for example, and they were reluctant to "make a fuss" about their experience. We wanted to capture the full community impact – the ripple effect – of the mass casualty. To better understand these effects, in early 2022 we invited interested people throughout Nova Scotia, all of Canada, and other countries to take part in the Share Your Experience survey.

The Share Your Experience approach was informed by input we received at the Commission's community open houses and through a web-based survey in the fall of 2021. We invited people to provide input and to participate through the Commission's website, regular stakeholder updates, proceedings, and social media channels. While most people chose to participate via an online survey, those who preferred other ways to share their experience were able to take part via a phone call, email, or a letter through the postal system.

To help us learn more about the types of people taking part, we asked survey respondents if they identified with one of a number of groups, including those most affected, first responders, affected community members, members of the public (in Nova Scotia, all of Canada, or another country), and advocacy groups. Respondents were then invited to answer these questions (see also Annex A):

- What was your experience during the events of April 18 and 19, 2020?
- Rate your sense of safety in your community (1) before April 2020, (2) in the weeks following the mass casualty, (3) present day.
- What was your experience in the weeks and months after the events?
- Have these events changed your day-to-day activities and/or behaviours, and how?
- Have these events affected your mental health and/or well-being? If yes, how?
- Are there any examples of your community coming together or of community support efforts after the mass casualty that you would like to share?
- Is there anything else you want the Commission to know about the impact of the events on you or your community?

People who identified as being first responders had the opportunity to answer additional questions, including if and how the mass casualty had affected their work. These survey response questions helped inform the Commission's work to better understand and engage with people working in police organizations and other kinds of emergency response.

The survey allowed anonymous submissions, taking into account that some people who had suffered traumatic experiences preferred not to give their names. It included the option for respondents to provide contact information if they were willing to have the Commission follow up with more questions. The survey began with advice about wellness supports, and members of the Commission's community public engagement team alerted members of our mental health and wellness team if a submission indicated that the respondent required assistance or support, enabling them to follow up where needed.

The Share Your Experience survey closed at the end of March 2022. More than 920 Canadians and interested people from other countries took part. The survey assisted us in building our understanding of the experiences of people in a range of different locations, contexts, and settings, including those living in affected

communities and those working as first responders. While responses varied, key themes from the responses included concern over the negative mental health effects arising from the mass casualty, the sense that communities or public spaces were less safe following the mass casualty, and a call for more access to and education about support services for people who have experienced trauma or require mental health assistance. All survey responses were reviewed by the Commission and helped to inform our work, including proceedings and this Final Report. A summary and analysis are included in Annex B: Reports.

In retrospect, we wish we had implemented the Share Your Experience initiative much earlier in our work and carried out concentrated outreach to groups such as underrepresented and incarcerated people who are difficult to reach. We had underestimated the community need for opportunities to share their accounts of the mass casualty and had sought to engage with members of the public about the Commission's process before creating this space. Clearly, it was not enough merely to acknowledge community impact, and we should have been more proactive in providing opportunities to learn directly from those who wanted to share their experience.

> Early consideration should be given to providing individuals and groups who have been directly and indirectly affected by the matters raised in the Inquiry's mandate with opportunities to share their experiences.

Rural Communities

The rural communities pod worked to develop an understanding of the rural context in Colchester, Cumberland, and Hants counties, where the mass casualty occurred, as well as aspects of life in rural communities more generally as they related to our mandate. The circumstances of the mass casualty required an understanding of rural policing, community safety, and health resources in these areas, as well as the prevalence of crime, the extent of poverty, and the relationship between poverty and crime and safety.

One of the facets of rural life can be closer relationships among community members and between the police and community members. The Commission investigated what relationships, if any, police might have had with the perpetrator and

what information, if any, police and community members might have had about the perpetrator, with a view to understanding whether either one might have influenced the course of events.

We commissioned two expert reports to add to our understanding of policing and community safety in the rural context. The first, “Crime Prevention & Community Safety in Rural Communities,” by Karen Foster,[57] provided us with the Canadian context. It addressed the “urban bias” that exists in research and policy development and explored what is different about rural places and what constitutes safe communities. The second report, by Dr. Anna Souhami, “A Systematic Review of the Research on Rural Policing,” enriched our understanding of the mass casualty and of possible ways to increase rural community safety.

At the outset of the public proceedings, we convened a panel drawn from the counties in which the mass casualty occurred, as described in the section on mental health and rural communities. Later in public proceedings, on June 30, 2022, we organized a roundtable to discuss rural communities, policing, and crime. The members of this roundtable addressed crime in rural communities, including the rates and nature of the crimes committed. They also considered firearms in rural communities, with a particular focus on rural attitudes toward the possession and use of firearms. Finally, they considered policing in rural communities, including the unique challenges to policing rural areas, and the core values and delivery of community-based policing.

The Commission also held a roundtable on “Rurality and Community Well-being” that deepened our understanding of the rural context in Nova Scotia, including the culture and attitudes specific to rural life. Members of this roundtable discussed the limited and differential service delivery in rural areas, the health and safety of people working there, and how their duties often go beyond what is expected in their professions. The discussion produced useful ideas about how best to support the health and safety of those who live and work in rural communities, including volunteer firefighters, the Victorian Order of Nurses (VON), teachers, social workers, and community organizers. It also provided additional context on what it is like to live in rural Nova Scotia, how rural infrastructure and community supports differ from those in urban areas, and about the inadequate resourcing of social and community supports.

Several of the reports reviewed in the environmental scan also discuss the differences between rural and urban policing in responses to gender-based and intimate partner violence and active shooter events. In particular, they note the time required for emergency response.

Firearms

The firearms pod worked to develop our understanding of the perpetrator's access to firearms and ammunition. It prepared a Foundational Document that set out the information we gathered about how the perpetrator acquired his weapons, including transborder smuggling. The document set out individual and community knowledge about his acquisitions as well as the opportunities available to report and respond to illegal firearms acquisition. Some Participants thought that firearms would be more properly discussed under the violence pillar. Although we explored the connection between guns and gender-based violence under that theme, we also needed to consider these questions within the broader context of rural gun ownership and community safety.

To address the direction in the mandate to explore access to firearms, we needed to understand the Canadian legal framework for the regulation of firearms, including the transborder issues under the Canada Border Services Agency. To that end, we commissioned two expert reports on firearms. In "The History of Gun Control in Canada,"[58] Dr. Blake Brown provided a legal history of firearms control, with attention to border control and illegal firearms. He explained the strategies that have been used in Canada to regulate firearms, the public policy debates about these strategies, and the policy measures taken to address the smuggling and illegal trafficking of firearms and associated paraphernalia. Finally, he identified the kinds of weapons that have been implicated in specific mass casualty events in Canada as well as the legislative or policy response, if any, to these events.

We commissioned an expert report for Phase 3 on firearms regulation in Australia, focusing on the policy response to a mass casualty event. "Firearm Regulation in Australia: Insights from International Experience and Research," by Joel Negin, Philip Alpers, and Rebecca Peters,[59] provided a detailed case study of the changes to firearms regulations that were adopted in the wake of the Port Arthur massacre in Tasmania in 1996. The report reviewed the effectiveness of the policy approach adopted by the Australian government and described the process used to build consensus and implement the relevant regulatory changes. It also evaluated the impact of the changes, in terms of gun violence and suicides, while offering appropriate cautions about the challenges of conducting these kinds of evaluations. Finally, the report reviewed changes to firearm regulation that have taken place in other jurisdictions, including in response to mass casualty incidents.

As part of our public proceedings, the Commission presented a Foundational Document about firearms. We heard about ballistics and forensic firearms examinations from a technical witness, Benjamin Sampson, who is a firearms scientist at the Ontario Centre of Forensic Sciences. We also heard Participant submissions on access to firearms, including enforcement, smuggling, and regulatory approaches.

The environmental scan included a number of reports on the acquisition and use of firearms, particularly on active shooter events and gender-based and intimate partner violence. These reports assessed a wide range of legal and policy interventions and made recommendations on topics such as the limitations of firearms registration systems, risk assessment, the limitations of reporting mechanisms when civilians are worried about safety as a result of the acquisition or presence of firearms, and the use of pro-removal policies in violent relationship situations.

We prepared a legislative brief and a policy booklet on firearms. The legislative brief summarized the law applicable to the acquisition, possession, transfer, import, and use of firearms at the time of the mass casualty in April 2020. Because the perpetrator did not have a firearms licence, the brief emphasized illegal possession, import, and use of firearms. The policy booklet summarized material reviewed by the Mass Casualty Commission regarding the policies and procedures of the Canada Border Services Agency with respect to firearms.

Post-event Support

The post-event support pod built the factual record around what types of information and support were available to survivors, families, and first responders and service providers affected by the mass casualty. This investigation involved both reviewing policies and practices and interviewing those engaged in providing and receiving the support services. Questions included whether the information provided to those most affected and to the broader community was appropriate, accurate, and timely; the handling of next of kin notifications; the role of specific institutions and programs in providing post-event support; and the adequacy of support services provided after the mass casualty. The pod prepared three Foundational Documents: next of kin notifications to families; resources and services requested by and provided to families; and support services available to the community. In addition, it helped to improve our understanding of the initial and ongoing impact of the mass casualty.

We commissioned two expert reports on post-event support: "Survivors and the Aftermath of the Terrorist Attack on Utøya Island, Norway," by Dr. Grete Dyb, Dr. Kristin Alve Glad, Ingebjørg Lingaas, and Dr. Synne Øien Stensland, and "Supporting Survivors and Communities After Mass Shootings: A Report Presented to the Mass Casualty Commission," by Dr. Jaclyn Schildkraut.[60] These reports provided overviews of empirical research and experience in Norway and the United States on how best to understand the needs of survivors and communities, how these needs may change over time, and how they may differ depending on the context of a specific mass casualty and the community in which it occurs. Dr. Schildkraut's report summarized helpful insights gleaned from research in the United States on the survivors of mass casualties and on communities that have experienced these incidents. By describing some of the approaches used in the United States to support survivors and communities, this report expanded its lens to include memorialization efforts and how communities can support other communities.

The report on the Utøya mass casualty in 2011 and its aftermath described the work Dr. Dyb and her colleagues did with survivors, first responders, and communities affected by the mass casualty in Norway. It connected their findings with other research into the impact of surviving mass casualty and terrorist incidents on individuals and communities. Based on this research, the authors suggested best practices for providing care to those affected by mass casualties, including the importance of offering a range of immediate, medium-term, and long-term supports.

In our public proceedings, the Commission presented a Foundational Document, "Information-Seeking from Families, and Next of Kin Notifications," which described how victims' families sought information about their loved ones and the RCMP's process of delivering next of kin notifications. The Commission heard witness testimony from RCMP member Cst. Nicholas (Nick) Dorrington about the delay in identifying fatalities on Cobequid Court, his actions during the mass casualty, and his prior interaction with the perpetrator. The Commission then presented two more Foundational Documents, "Support Services for Survivors, Families, and Communities" and "Public Communications from the RCMP and Governments After the Mass Casualty." The Commission also heard witness testimony from Cst. Wayne "Skipper" Bent, who was the RCMP family liaison for victims' families after the mass casualty, about his role and work. In addition, Dr. Schildkraut appeared as an expert witness to discuss her report.

The Commission facilitated two roundtable discussions that addressed the needs of families, communities, and first responders after mass casualty incidents. As with other public proceedings, recordings of the roundtables were posted on our website. The first roundtable focused on the needs of survivors, family members, and communities after mass casualty incidents. The roundtable members discussed the immediate, short-term, and long-term needs of those affected by a mass casualty, with particular attention on the needs of the families of the victims and members of communities closely connected to a mass casualty; best practices for addressing those needs; and existing models that support grief, promote healing, and foster resiliency. The second roundtable focused on the needs of first responders after mass casualty incidents – the immediate, short-term, and long-term needs of first and second responders exposed to traumatic situations by virtue of their jobs; best practices for addressing those needs; and existing models that provide support, promote healing, and foster resiliency.

Panellist Profile: Mary Fetchet

Mary Fetchet is the president and executive director of Voices Center for Resilience (VOICES), an organization she founded following the death of her 24-year-old son on 9/11. She is a graduate of Columbia University's School of Social Work, and her 29 years of experience as a clinical social worker influenced VOICES' innovative approach to providing long-term support for victims' families, responders, and survivors, and commemorating the lives lost in a meaningful way. Ms. Fetchet shares lessons learned through VOICES' experience to assist communities affected by other tragedies, to define best practices in preparing for and responding to acts of mass violence, and to advocate for public policy reforms for making communities safer.

Several of the studies on gender-based and intimate partner violence included in our environmental scan review make recommendations concerning the availability of services for individuals experiencing abusive relationships, but none deal with post-event support in the context of a mass casualty. Although not directly within the scope of our mandate, some of the recommendations have a general relevance, including, for example, recommendations concerning how to ensure that support services are available to differentially affected groups. Given these gaps, our research and policy team reviewed other kinds of studies, including academic research into and policy reports on the needs of those affected by mass casualties.

Violence

Mass Casualties and "Private" Violence

The Commission's violence pod worked to develop our understanding of three sets of issues:

- the sociology of mass casualties;
- what is known about the perpetrators of mass casualty events (and how those events are understood as "public" violence); and
- the phenomena of intimate partner violence, gender-based violence, and family violence (often characterized as "private" violence), as well as community and police responses to these phenomena more generally.

The pod prepared a range of Foundational Documents bringing together information the Commission had gathered concerning the perpetrator's antecedents, including violence toward his common law spouse and others, violence within his family, and his financial misdealings (financial and commercial misdeeds). This work included identifying and interviewing potential witnesses and adding their statements to our inventory of documents.

We commissioned several expert reports to deepen our understanding of the types and dynamics of violence involved in the mass casualty. Two of them dealt with the sociology of mass casualty events: Dr. Tristan Bridges and Dr. Tara Leigh Tober provided the US context in "Mass Shootings and Masculinity";[61] and Dr. David C. Hofmann, Dr. Lorne Dawson, and Willa Greythorn prepared a report on "Core Definitions of Canadian Mass Casualty Events and Research on the Background Characteristics and Behaviours of Lone-Actor Public Mass Murderers."[62] Bridges and Tober's report discussed debates about the definition of a mass shooting and how these debates have shaped what is known about the phenomenon of mass casualties – for example, the inclusion or exclusion of incidents involving intimate partner or family violence, and gang violence or incidents that play out over multiple locations. It discussed the sociological concept of gun culture and why, in order to understand statistical trends in gun violence, it is important to focus on gun culture and not only on the rates of gun ownership. Finally, it discussed the cultural aspects of masculinity, and why varying cultural conceptions of masculinity can affect rates of gun violence.

The report from Hofmann, Dawson, and Greythorn addressed two key topics. First, it discussed Canadian mass casualties, providing a lengthy list of incidents since 1970 and suggesting a definition of mass casualties to assist research and policy-making. Second, this report provided a synopsis and evaluation of research on the sociological, demographic, and psychological characteristics of perpetrators of mass casualty and terrorism. This synopsis was largely based on US research. The list of Canadian mass casualty incidents provided a helpful reference point for the broader context in which the Commission studied the mass casualty of April 18 and 19, 2020, and assisted us on associated matters such as patterns in the means used for mass casualties.

The relationships among mass casualties, family violence, and gender-based violence were explored in greater depth in the report by Dr. Jude McCulloch and Dr. JaneMaree Maher, "Understanding the Links Between Gender-Based Violence and Mass Casualty Attacks: 'Private' Violence and Misogyny as Public Risk." This report described research that has shed light on the prevalence of gender-based and intimate partner violence as a precursor to, and integral aspect of, mass casualties. It also explained the challenges associated with conducting this research. The authors suggested that experience in family violence and gender-based violence may help researchers, policy actors, and community safety agencies better understand, prepare for, and potentially prevent mass casualties. The authors also considered how other forms of inequality and marginalization – such as racism and Islamophobia – are implicated in the perpetration of mass casualties.

"Understanding Violence in Relationships," by Dr. Carmen Gill and Dr. Mary Aspinall,[63] provided background information on gender-based, family and intimate partner violence and coercive control. It defined these phenomena and explained what is known from empirical studies of how these forms of violence manifest in Canada and, more specifically, in Nova Scotia. The report presented an overview of the research on police perceptions of and responses to these phenomena, and also identified barriers to reporting these harms and to other non-state responses, such as assisting abused persons to leave relationships.

"Rigorous Forensic Psychological Assessment Practices," by Dr. Kristy Martire and Dr. Tess Neal,[64] defined the field of forensic psychological assessment and drew on decades of research to lay out eight best practices that may be used by law enforcement agencies and courts to evaluate the rigour and value of a psychological evaluation. This report, drawing on Dr. Martire and Dr. Neal's expertise in psychology, aided the Commission in assessing the extent to which the "psychological

autopsy" and "behavioural profiles" produced about the perpetrator of the April 2020 mass casualty reflected evidence-based techniques and best practices in forensic psychology.

"When We Know Something Is Wrong: Secondary and Tertiary Intervention to Address Abuse Perpetration," by Dr. Katreena Scott,[65] reviewed research on intimate partner violence interventions and presented a vision for a comprehensive system of specialized interventions for perpetrators that prompts involvement as early as possible, through as many doors as possible, in a "web of accountability" for keeping perpetrators in view while working to promote victim safety and perpetrator change.

"Conceptions of Masculinity and Violence Towards a Healthier Evolution of Men and Boys," by Brian Braganza and Nick Cardone of Free Range Therapy,[66] focused on concepts of masculinity, the harmful effects of "traditional" understandings of masculinity, and options for building healthier concepts of masculinity. The authors identified the ways in which traditional masculinity may contribute to problems with the mental health of men and boys and their understanding of gender roles and gender-based conflict. The report explored the connection between violence and masculinity, including gender-based and intimate partner violence, bullying and intimidation, and mass shootings. It also examined the barriers men often face in seeking help through traditional therapeutic approaches for physical and mental illness and the effects of trauma. Finally, the report identified and evaluated other options for treatment and interventions which are aimed at helping men to build healthier expressions of masculinity.

"The Health and Safety of Survival Sex Workers in Halifax and Truro, Nova Scotia," by Dr. Gayle MacDonald and Dr. Meredith Ralston of Mount Saint Vincent University,[67] examined how sex workers experience community safety in Nova Scotia, how they ensure their own safety, and their relationships with community agencies such as the police, the healthcare system, and other service providers. The authors also looked at barriers to reporting victimization, including distrust of both the provincial healthcare system and the police. They recounted the experiences of sex workers who are marginalized because they are Indigenous, belong to racialized or 2SLGBTQI+ groups (or engage in sexual activity with 2SLGBTQI+ people), or for other reasons.

We commissioned two additional expert reports that could not be completed by the writers because of personal circumstances. One, to examine the history of the police duty to warn the public in Canada, would have drawn on relevant examples

from other cases and instances in which the duty to warn has been explained and/or applied. It would have explained the purpose of the duty as described in case law, reports, and academic literature and, where relevant, discuss the history of debates about the purpose, scope, and limits of the duty. The other report, to define the concepts of risk assessment, prediction, prevention, and late enablers, would have explained the use of these psychiatric terms in understanding the perpetration of mass casualty offences. The report would also have reviewed and assessed the psychiatric literature on whether there is or could reasonably be a meaningful profile for those at risk of perpetrating mass casualty offences. Finally, it would have identified challenges to developing evidence-based approaches to preventing or predicting the perpetration of mass casualty events and to understanding them after they have occurred.

In July and August 2022, our public proceedings focused on the violence pillar, covering topics such as risk assessment and the perpetration of mass violence, community safety in rural areas, gender-based and intimate partner violence, the perpetrator's history of violence and financial misdealings, and policing oversight. We did so using Foundational Documents, expert reports, roundtables, and witness testimony. For two weeks in July 2022, we focused on understanding gender-based and intimate partner violence and explored the connection between mass casualties and these forms of violence.

Early in the process, the Commission teams wrestled with whether to include the perpetrator's interactions with Lisa Banfield on April 18, 2020, in the draft location-based Portapique Foundational Document. We felt that it was necessary to look in detail at the antecedents to the mass casualty. It was clear from the evidence we had already obtained that gender-based and intimate partner violence were among those antecedents. However, we also believed it was important to share more information about these antecedents with the public before seeking to explore Ms. Banfield's experience in public proceedings. Some Participants disagreed vehemently with our approach. Feedback on draft Foundational Documents conveyed outrage at the decision to leave a close exploration of Ms. Banfield's role and experience until later in our proceedings, and some Participants demanded that we call Ms. Banfield at the outset of our proceedings. We felt equally strongly that if we had subpoenaed Ms. Banfield at that time, she would have been entitled to refuse to answer many of the questions Participants wished to put to her, because of her pending charges related to the acquisition of ammunition for the perpetrator. We also felt strongly that Ms. Banfield's evidence

about the perpetrator's violence toward her would be better understood by all concerned if she were able to answer questions freely.

On the day that the charges against her were diverted to the Nova Scotia Restorative Justice Program in March 2022, Ms. Banfield presented herself at the Commission offices and offered her co-operation with the Inquiry. By July 2022, the Commission had interviewed Ms. Banfield over five lengthy sessions totalling 14 hours and was able to present three Foundational Documents that provided evidence of violence within the perpetrator's family, the perpetrator's violence toward others, and the perpetrator's violence toward his common law spouse, Ms. Banfield. We anticipated that this evidence would help us to identify red flags that may have been missed, focus on possible pathways for prevention and intervention, and profit from lessons learned. This work was critical as we continued to develop recommendations to help make our communities safer. We also anticipated that the combination of all this related evidence and information would assist the public in better understanding the pervasive effects of gender-based and intimate partner violence.

Over the course of the two weeks set aside in July, the Commission heard from 23 experts about the connections between gender-based violence and mass casualty incidents, police and institutional responses to intimate partner and family violence, police and institutional responses to sexual violence and other forms of gender-based violence, and personal and community responses to this violence. These experts contributed research-based insights, front-line expertise, and decades of experience working on questions associated with gender-based violence and intimate partner violence, including in rural communities, to the Commission's consideration of these issues pursuant to our mandate. Combining the presentation of Foundational Documents with witness testimony and roundtable discussions allowed us to explore what happened during and leading up to the mass casualty, while also contextualizing the evidence that was specific to this perpetrator, and this mass casualty, within well-documented patterns of violence and state and community responses to violence.

In one expert witness panel, Dr. Bridges and Dr. Tober discussed their report on how cultural factors, including cultures of masculinity, help to produce mass violence. The Commission then presented our Foundational Document about violence in the perpetrator's family, followed by testimony from expert witness Dr. Deborah Doherty, a community-based researcher who has studied family violence and gender-based violence in rural communities in Atlantic Canada.

After the Commission presented the Foundational Document on the perpetrator's violence toward others before the mass casualty, we heard testimony from Brenda Forbes, a former neighbour of the perpetrator, who provided information about her knowledge and experience of the perpetrator's violent behaviour. In another expert witness panel, Dr. Jude McCulloch and Dr. JaneMaree Maher discussed their report, "Understanding the Links between Gender-Based Violence and Mass Casualty Attacks: 'Private' Violence and Misogyny as a Public Risk." The Commission then presented our Foundational Document about the perpetrator's violence toward his common law spouse, Ms. Banfield.

In this week, we also hosted two roundtable discussions: In the first, "Prediction and Prevention of Mass Casualty Events," members discussed whether mass casualties can be predicted and whether effective risk assessment models exist. They spoke about the availability of early intervention and preventive strategies, given the state of our knowledge about perpetrators of mass casualties, and explored steps Canadian institutions and citizens can take to try to prevent these events in the future.

In the second roundtable, "Definitions and Psychology / Sociology of Perpetrators of Mass Casualty Events," members discussed how mass casualties are defined, the debates regarding their definition, and why the way we define mass casualties matters. They explored the topic of identifying the perpetrators of mass casualties, including their common characteristics, and how gender is relevant to patterns of perpetration, followed by discussion of early intervention and prevention strategies and the role of adverse childhood experiences in the perpetration of violence.

On July 15, 2022, we heard from Lisa Banfield, the perpetrator's common law spouse. After the Crown had referred the charges against her to the Restorative Justice Program, Ms. Banfield voluntarily participated in five interviews with the Commission (more than any other witness) and shared other evidence that proved key to the Commission's independent investigations. The interviews provided a large amount of information on a wide variety of subjects, including the violence, coercion, and control Ms. Banfield experienced during her long relationship with the perpetrator and her experiences as the first target of his violence on April 18, 2020. We Commissioners agreed that, given Ms. Banfield's unique situation as both a factual witness to the beginning of the mass casualty and as one of those most affected, it was necessary to hear from her directly in proceedings. Moreover, Ms. Banfield had expressed a desire to testify in person.

As with all other witnesses who were questioned during public proceedings, the Commission subpoenaed Ms. Banfield to appear before us. We directed that she could be joined by support people, and her sisters Maureen and Janice sat beside her throughout the day of testimony. We also directed that she would be questioned solely by Commission counsel in their role representing the public interest. Participant counsel were invited to provide questions in advance, as well as during two caucus meetings, for Commission counsel to put to Ms. Banfield before she was excused as a witness.

In the following week, the Commission hosted a roundtable discussion, "Exploring the Connections: Mass Casualties, Intimate Partner Violence, Gender-Based Violence, and Family Violence," where members discussed the relationship between forms of violent behaviour that tend to be understood as private, such as intimate partner violence, gender-based violence, and family violence, and violent behaviour, such as mass casualties, that is characterized as public. They debated how moving away from the private / public distinction would generate new understandings of potential preventive strategies, interventions, and responses to mass casualties. Finally, they spoke about research into the underlying causes and factors that enable intimate partner violence, gender-based violence, family violence, and mass casualty incidents and the relevance of this research to policy-making.

After the roundtable, the Commission presented a Foundational Document about the perpetrator's financial misdealings – his banking activity, corporate dealings, real estate acquisitions, and improper patient billing practices. This information, by allowing us to explore financial red flags in his past that may have been missed by police, government, and financial institutions, helped to inform our recommendations. Although our investigation was ongoing and we continued to share information in proceedings and on our website, the presentation of this 31st and final Foundational Document brought together the factual information the Commission had gathered about the mass casualty.

The Commission also prepared a legislative brief to provide information about legislation applicable to gender-based violence (GBV), intimate partner violence (IPV), family violence, and coercive control, along with additional perpetrator antecedents and financial dealings. This document is not a comprehensive overview, and it does not address offences committed by the perpetrator during the mass casualty.

Following the presentation of our final Foundational Document, the Commission heard witness testimony from Cst. Troy Maxwell to address factual gaps relating to his response to a complaint Brenda Forbes made to the RCMP on July 6, 2013.

Later that week, the Commission facilitated three more roundtables. In the first, "Police and Institutional Understanding and Responses to Intimate Partner Violence and Family Violence," members discussed the barriers to effective police and other institutional responses to intimate partner violence and family violence. They considered the cultural aspects of these barriers and how they can be addressed, followed by a discussion about promising and best practices in police and institutional responses, both in Canada and abroad.

The second roundtable, "Police and Institutional Understanding and Responses to Sexual Violence and Other Forms of Gender-Based Violence," covered themes such as the barriers to effective police and other institutional responses to sexual violence and other forms of gender-based violence. Members considered the cultural aspects of these barriers and how they can be addressed effectively, as well as the promising and best practices in police and institutional responses, both in Canada and elsewhere.

The third roundtable, "IPV, GBV, and Family Violence: Personal and Community Responses," focused on several key questions:

- What do we know about the social and material conditions that nurture and sustain gender-based violence? How can these conditions be addressed or transformed?
- What are the barriers to community-based interventions and support, particularly in the rural context? How can these barriers be addressed?
- What support services are available to women who experience these forms of violence?
- What does work? What are some of the promising or best practices with respect to personal and community responses, both in Canada and internationally?

The following day, the Commission heard from Dr. Martire and Dr. Neal in a witness panel as they discussed their expert report, "Rigorous Forensic Psychological Assessment Practices."

The Commission's environmental scan provided an overview of 32 reviews on gender-based and intimate partner violence which addressed issues relevant to our mandate. These reviews contained a wide range of recommendations for reform, including police responses and risk assessment tools, responses by other institutions, and the intersections of policing and other responses. In some instances, recommendations had been made repeatedly over the years and across Canadian jurisdictions. We reviewed these recommendations carefully to try to understand obstacles to implementation while focusing on what might have made a difference in the circumstances of this mass casualty.

As part of our work to examine previous recommendations related to gender-based and intimate partner violence, and to identify earlier opportunities for intervention and prevention in the perpetrator's violent past, we heard witness testimony from RCMP Cst. Greg Wiley. Cst. Wiley was stationed in Nova Scotia from 2006 to 2018. He provided information about his involvement in the case of Susan (Susie) Butlin; his interactions with the perpetrator predating the mass casualty; and his involvement in RCMP, Halifax Regional Police, and Truro Police Service investigations into the perpetrator resulting from the perpetrator's threats to kill his parents in 2010 and a police officer in 2011.

Finally, the Commission prepared a legislative brief and a policy booklet on violence. The brief provided information about legislation applicable to gender-based violence, intimate partner violence, family violence, and coercive control as well as additional information about the perpetrator's earlier behaviour and financial dealings. The booklet provided an overview of the policies adopted by the provincial government in Nova Scotia concerning intimate partner violence, family violence, and gender-based violence along with the relevant policies followed by the RCMP, municipal police, and regional police in the province.

Focused Consultations with Members of Specific Differentially Affected Communities

The Commission provided members of the public with a variety of ways to share their expertise and experiences. Even so, some community members were unable to participate in or were mistrustful of the Commission's consultation processes

because of historical and ongoing disenfranchisement from both institutional and legal processes. In particular, through witness interviews and information provided by some Participant organizations, the Commission became aware that women from certain differentially affected communities had evidence and input relevant to the Commission's mandate. We also learned that some witnesses were unlikely or unable to share their experiences via the Commission's standard evidence-gathering avenues.

Avalon Sexual Assault Centre (Avalon) and the Elizabeth Fry Society of Mainland Nova Scotia (Elizabeth Fry Society) were Participants in our process who have considerable expertise and experience in working with racialized and criminalized women and gender-diverse persons. Both Participants had received information from some of their clients indicating they had evidence and input relevant to the Commission's mandate. These Participants offered to engage and facilitate the Commission's consultation with these communities.

Avalon's community navigator arranged for a facilitated consultation with a small group of African Nova Scotian women who had experienced sexualized violence. Avalon is a community organization that offers a continuum of specialized services to those experiencing sexual violence at the intersections of other forms of oppression and marginalization. Services include support, counselling, education, immediate medical care, forensic evaluation, navigation, leadership, and advocacy.

The Elizabeth Fry Society facilitated consultation with inmates at the Nova Institute for Women in Truro, Nova Scotia (Nova). This society is the provincial branch of a national organization that works with and on behalf of incarcerated and otherwise criminalized women and gender-diverse persons. It advocates for systemic changes within our justice system that will promote equality, safety, and security for the most marginalized members of our community.

Consultation Process with Avalon

In November 2021, the Commission conducted an interview with Melinda Daye in which she said that the perpetrator was well known within African Nova Scotian communities for predatory behaviour toward women. After this interview was shared with Participants, Avalon submitted a proposal to the Commission in the spring of 2022 to provide a culturally responsive and trauma-informed safe space where survivors from differentially affected communities could share their experiences about the mass casualty and gender-based violence.

In July and August 2022, the Commission arranged for four sessions at various locations in Halifax and Dartmouth, Nova Scotia. Sessions were approximately three hours long and held in a private room at a public location identified by participants as a safe space. Counselling support was available to participants during and outside sessions. Commission staff were present during sessions and provided logistical assistance with booking rooms and refreshments, but these sessions were designed and led by Avalon and facilitator-participants from African Nova Scotian communities. Approximately five individuals attended each of these sessions, two or three of whom attended all or most of the sessions.

Session participants were invited to discuss the following topics:

- themes of gender-based violence perpetrated on marginalized individuals;
- reasons for and barriers to survivors reporting violence;
- gaps in services and barriers to connecting with existing services; and
- recommendations for better addressing gender-based violence.

The format was free-flowing and participant-led. Circle sharing, breakout sessions, and individual conversations with counsellors were used throughout the session meetings. Facilitators sought suggestions from attendees regarding the format of future meetings. Session participants reviewed and consented to the final report, in which their input was aggregated and anonymized, before it was submitted to the Commission and made available to the public.

At least one Commission member trained to conduct interviews attended each session in the event that a participant decided she wished to provide evidence directly to the Commission. Two witnesses who had direct interactions with the perpetrator in circumstances where he was arranging or attempting to arrange sexual acts from African Nova Scotian women in exchange for drugs, money, and/or denturist services agreed to give formal interviews to the Commission.

Avalon's process provided evidence about the perpetrator's predatory behaviour toward certain historically marginalized women as well as contextual information that assisted the Commission and our Participants to understand this evidence. Avalon's subsequent report of its process discussed a variety of reasons why historically marginalized women tend not to report sexual abuse, including normalization of sexual violence from an early age, fear of not being believed or, if believed, increased likelihood that their children would be apprehended by protective services. Interviews provided by witnesses offered further direct evidence of the

perpetrator's history of violence and predatory behaviour. This process provided the Commission with rich evidence about why violence and predatory behaviour may not be reported to authorities including police and professional bodies. Given the deep mistrust of institutional processes within this population, adopting this community-led approach allowed us to gather evidence that we would not otherwise have received.

Consultation Process at Nova Institution for Women

Nova Institution for Women (Nova), located in the Town of Truro, is one of six federal facilities for incarcerated women in Canada. Several women at Nova were directly affected by the mass casualty because they had known Alanna Jenkins, a long-time employee of Nova who was serving as a correctional manager at the time of her death on April 19, 2020. The Elizabeth Fry Society advocated for the Commission to visit Nova in order to give these women the opportunity to share their experiences and provide input to the Commission's work. It also suggested that this population could offer important insights into the lives and perspectives of women who experience gender-based violence, family violence, and intimate partner violence.

On September 28, 2022, a delegation of Commission staff went to Nova along with several staff from the society and two trauma therapists from Avalon. All minimum- and medium-security residents of Nova were invited to attend the two-hour session, which was advertised the week before via posters, Nova's special programs officers, and a loudspeaker announcement just before the session began. A total of 27 people attended.

Commission staff provided an overview of the Commission's work, and the executive director of the Elizabeth Fry Society facilitated a circle discussion with three rounds on the following topics:

- introductions and reason for attending the session;
- reflections on the ways abuses and harms against women are ignored, the criminalization of abused women, and what might be done differently; and
- for those who resided at Nova at the time of the mass casualty, what it was like to experience the mass casualty while in prison and to lose Ms. Jenkins.

The session was not recorded, but Commission staff took notes identifying themes that emerged from the discussion. One Commission member trained to conduct interviews was available if a participant decided to provide evidence directly to the Commission.

The discussion with women residing at Nova provided another opportunity for the Commission to hear first-voice accounts of women who had experienced gender-based or intimate partner violence. Most participants disclosed that their histories included physical and/or sexual abuse. Several described the courage required to disclose experiences of violence, followed by feelings of despair and isolation when family or individuals in positions of authority minimized their experiences or did not believe them. The experience of not being believed was repeatedly cited as a reason for not reporting abusive behaviour. Hearing about these women's experiences helped us in our task of developing recommendations that take account of the practical realities that commonly inhibit the early and effective reporting of red flags.

The strict time constraints meant that participants did not have time to speak to the final question. However, a few women, in the course of reflecting on the first two topics, spoke about the difficulty of grieving Ms. Jenkins's death within the institution. Several Nova staff took leave from work after the mass casualty, and, as a result, women housed in medium- and minimum-security units were locked down (the women could not leave their residential units). In addition, COVID-19 restrictions prevented the women from gathering to commemorate or memorialize Ms. Jenkins.

> Time is required to work with those differentially affected, to earn respect and trust, and to find ways to work together to gather information in a safe and respectful way.
>
> Without collaboration and effort, key people and crucial information are left out of processes.

We heard throughout the Inquiry about the ripple effects of the mass casualty and the impact of COVID-19 on the grieving process. Another ripple was added when we heard from women at Nova as they spoke about their relationship with Alanna Jenkins, the impact of her loss, and not being able to mourn her or to celebrate her life.

Phase 3: Shaping and Sharing

Purpose and Approach

Phase 3 of the Commission's work focused on the third branch of our mandate: to distill the lessons learned from the mass casualty and make recommendations to help ensure the safety of our communities in the future. This final phase was the culmination of all the steps we had taken – from the initial design of the Inquiry to developing the framework, working with Participants to gather the evidence and information to create a comprehensive record about what happened in the mass casualty, how and why it happened, and sharing this record with the public.

As a cornerstone of our proceedings, we also created additional opportunities for input on our recommendations and their implementation. As we said in our Phase 3 opening remarks: "Now we have the opportunity to build on those foundations and have conversations about the kinds of recommendations that will make a real difference."[68] These Phase 3 activities were designed both to solicit concrete proposals for recommendations and to foster dialogue in support of the implementation and change processes emanating from the Commission's Final Report.

The preparatory work necessary to develop effective recommendations began in the early days of our mandate. We sought advice from experts in public inquiries and from the Research Advisory Board about how best to design our recommendations process.

In the vast majority of interviews, Commission staff asked witnesses to share their views on potential recommendations, just as they did with individuals who testified in public proceedings and those participating in roundtables. The expert reports we commissioned helped us to identify and develop potential recommendations. We invited submissions from Participants at the end of Phase 1 and Phase 2 and in their closing submissions. **One of our priorities in Phase 3 was to create collaborative discussions among Participants about promising directions for change and options for reform as well as the obstacles to implementation and strategies to overcome them.** Toward this end, we convened sectoral consultations with organizational Participants, held small group sessions with individual and family Participants, and arranged issue-based group consultations with individual and family Participants.

Throughout our activities in Phase 1 and Phase 2 and through education and public and community outreach, the Commission invited everyone to share their views on how to make our communities safer. **Specifically in our community outreach, we made the point that the Commission would disband at the end of the mandate and it would be up to individuals, organizations, and communities to carry forward the recommendations we made. It was essential for us to invite input and to foster individual, collective, and institutional commitment.** Many people took us up on this invitation through the Share Your Experience survey and in other communications. We built on this foundation by offering two structured public submissions processes and holding a consultative conference, community conversations, and stakeholder consultations.

Commission staff were also encouraged to share their ideas for recommendations throughout our mandate and to develop a "recommendations bank" that was updated regularly. We organized debrief sessions with groups of staff members and the thematic pods. After the close of public proceedings, we facilitated a full staff dialogue on key outcomes and hopes for the Final Report.

Over the course of the Commission mandate, we received more than 2,500 proposals for recommendations. Potential recommendations were collated in a compendium and organized by source, theme, and topic before being closely analyzed by Commission staff and reviewed by us. The information received extended beyond specific proposals to contextual information, all of which informed our deliberations and assisted us in shaping our Final Report and recommendations.

Our Phase 3 work was compressed and the timing was challenging, especially as we continued to hear witness testimony and to receive further material. The accumulation of this new information was particularly onerous on Participants because at the same time we were asking them to focus on their suggestions for recommendations. Notwithstanding these limitations, we believe our approach was an effective way to learn and share insights and, ultimately, contribute to greater community safety.

Activities

Public engagement on potential recommendations and guidance for implementation can be facilitated through a range of mechanisms including online surveys and facilitated discussions.

Discussion Guide

Throughout its mandate, the Commission shared with the public all the evidence and information it gathered and developed. This work included gathering tens of thousands of documents for review, conducting hundreds of interviews, hearing from witnesses and experts in public proceedings, and sharing information with the public about what happened during the mass casualty as well as how and why it happened. In our communications, we encouraged members of the public to engage with this information as a way of preparing them to participate in our public engagement activities and prepare to have a role in implementing the Commission's Final Report. Our website facilitated navigating this material and highlighted the Foundational Documents, the research and commissioned reports, and the proceedings webcasts as key resources.

At the same time, we recognized the challenges created by the sheer quantity and complexity of this information. In response, we sought to minimize these barriers by using a variety of communications and updates.

In Phase 3, for example, the Commission developed a Discussion Guide to make it easier for members of the public, community organizations, and agencies to share their suggestions for change (included in Annex A). The guide provided a brief introduction to the issues being analyzed by the Commission:

- public communications during an emergency;
- supporting people after a mass casualty;
- gender-based and intimate partner violence;
- community safety and well-being;

- policing structures and approaches;
- firearms access; and
- police paraphernalia.

The Discussion Guide also included questions related to these issues to assist people in having conversations about potential recommendations and relevant research with their families, friends, neighbours, and co-workers.

> Public input can be facilitated through both the open sharing of information and the preparation of summary guides to key issues.

Public Submissions

Rule 68 of the Commission's Rules of Practice and Procedure states, "Any interested person may make a public submission in writing to the Commission in response to any matter raised in the course of the Commission's work." Public submissions could be made at any time from the beginning of the Inquiry, and, sporadically, members of the public did provide us with their thoughts on various issues by email and by phone. The Commission also provided two structured opportunities for public submissions via online surveys to further encourage this type of participation.

The first survey was opened on April 25, 2022. At this time, the Commission invited members of the public to share suggestions for relevant research and for potential changes they would like to see implemented to make their communities safer, as well as recommendations they wanted us to consider as we prepared the Final Report. Although we encouraged people with relevant professional or personal expertise to make submissions, we also welcomed suggestions from people who were not experts.

Bringing more voices into the conversation was crucial to our work. We understood from the beginning that it would be up to all Canadians – policy-makers, public institutions, community groups, and members of the public – to accept the recommendations we put forward and turn them into actions. The submissions

process was designed so that members of the public could easily contribute their recommendations to the Final Report in a straightforward and accessible way.

Most public submissions were collected via a survey on the Commission's website, although other channels were made available for those who did not wish to complete the survey. The survey included identifier questions where respondents could indicate if they were a family member or survivor, first responder, affected community member, academic, policy-maker, advocacy group representative, member of the public in Nova Scotia, member of the public in Canada, and/or member of the public from outside Canada. The survey was promoted on our social media channels, during public proceedings, in stakeholder updates, and on the Commission's website.

People interested in making a submission were supported with guidance about the Commission's broad areas of focus relating to violence, policing, and community. We received well over two hundred public submissions through this phase, the majority relating to research or recommendations about policing (62%), followed by those focused on community (24%) and violence (14%). Incoming submissions were shared regularly with the Commission's research and policy team, and a summary was prepared to assist us in writing this Report.

The call for research-related public submissions through the online survey closed on September 1, 2022. We received valuable input through this phase, but also saw people who wanted to make suggestions but would not complete the online survey, likely because it was more complex than they expected. After closing the research and policy focus, we opened a second public submissions process using a simple form through which people could give their suggestions and recommendations without having to put them in a particular category or feel they were expected to provide research to support them. We wanted to ensure that we removed as many barriers as possible to maximize the response. We launched our Discussion Guide in conjunction with this second survey.

In all, we received another 231 submissions on a variety of topics and via the survey, email, phone, direct mail, and social media. We closed this process on October 10, 2022, to give us time to review and compile all the suggestions and consider them for our Final Report. We are grateful to all members of the public who provided suggestions and input for recommendations to help make our communities safer.

Consultative Conferences

As part of our work to fulfill our mandate, which included focusing on individuals or groups that may have been differentially affected by the mass casualty, the Commission designed two consultative conferences as part of Phase 3: the first to hear from members of the African Nova Scotian communities, and the second, from members of Indigenous communities. We chose the term "consultative conference" as a reference to the approach taken by the Marshall Inquiry in 1989 into the wrongful murder conviction of Donald Marshall Jr., a Mi'kmaw man.[69] These conferences were intended to provide an opportunity for the Commissioners and the Participants to hear from representatives of these communities about potential recommendations, including how best to ensure that their distinctive strengths and experiences were fully and respectfully factored into the Commission's recommendations on matters within its mandate.

The consultative conferences recognized that issues in our mandate, such as policing and violence, have a disproportionate adverse impact on African Nova Scotian and Indigenous communities and on individuals who belong to those communities. It was important that we heard directly from members of these communities about how the Commission's recommendations may affect their communities and to develop recommendations that do not have unintended adverse consequences on them.

It was also important that these communities had a voice in how they wanted to be consulted. Members of Indigenous communities proposed a talking-circle format for their consultative conference, which included conversations about the mass casualty; cultivating community safety; the role of police and other organizations; Indigenous policing services and police services that serve Indigenous communities; access to firearms; gender-based violence and intimate partner violence; the needs of communities, including culturally competent services; and the quality and stability of funding for services needed by communities.

The consultative conference was held on September 13, 2022, as part of the Commission's proceedings and was webcast. The members of Indigenous communities who engaged in this conference were leaders who generously volunteered their time and expertise and contributed hugely to our understanding, including on issues such as the history of the implementation of the Marshall Inquiry recommendations and relations between police and community leaders in Indigenous communities in Nova Scotia. The session began with a welcome and smudge by

Elder Marlene Companion and was facilitated by Cheryl Copage-Gehue, an advisor for Indigenous community engagement for the Halifax Regional Municipality and a Mi'kmaw woman from the Sipekne'katik First Nation, near the town of Shubenacadie, Nova Scotia. Noel Brooks and Luke Markie, members of the Millbrook First Nation, participated in the circle. The perpetrator drove through their community during his rampage on April 19, 2020. Millbrook First Nation is the home community of family, friends, and first responders among those most affected, including Connor Reeves, Corrie Ellison's son.

Though the Commission intended to hold a consultative conference with members of African Nova Scotian communities, to ensure their perspectives and experiences were reflected in the conversation about potential recommendations, this session had to be cancelled owing to scheduling conflicts between the Commission's proceedings and the representatives' other commitments. The Commission still had the benefit of learning from interviews we conducted with members of the African Nova Scotian communities, including through Avalon. We had also heard from community members at roundtables, and we continued to consult with those representatives. We regret that we were unable to more consistently adapt our procedures to hear from communities in ways that best suited them.

Community Conversations

In Phase 3, the Commission's research and policy team and public engagement team hosted six community conversations in five Nova Scotia communities to discuss perspectives on community safety. These conversations took place in Great Village, Onslow, Debert, Millbrook, and Truro. We recognized that employees of the Victorian Order of Nurses play an integral role in community safety in rural Nova Scotia, and the mass casualty had a substantial impact on this community. Two of their colleagues, Kristen Beaton and Heather O'Brien, were killed on April 19, 2020. For these reasons, we also conducted a community conversation with employees of the VON. We arranged mental health support for anyone who required it during and after the meetings. In these conversations, community members spoke about their community, identified lessons learned after the mass casualty and current barriers, and shared recommendations to enhance overall safety and well-being. Community conversations helped the Commission gain perspective on how the mass casualty affected feelings of safety and provided lessons learned from the mass casualty in different communities.

Each conversation discussed the unique challenges and barriers faced by rural communities in Nova Scotia – in particular, the need to foster a better sense of community cohesion and support in these communities. One suggestion that emerged was to create an open space in which community members could gather. Participants also identified barriers in the community that hindered safety, including a lack of spaces for the community to connect, limited transportation to access community resources, stigma, isolation, and communication issues. Members in community conversations also noted a lack of timely and adequate mental health and bereavement support as a barrier faced by individuals in rural communities.

Some conversations included discussions about communities seeming closer since the mass casualty. They identified ways in which communities support each other, such as using fire halls as community hubs and Legion halls as spaces to connect. A few of the conversations occurred around the time that Hurricane Fiona passed through, and people told stories of community members coming together to support each other when neighbours had no power or were faced with fallen trees in their yards and other emergency situations. They called this collaboration and support a vital resource for the community during times in need.

Commission staff who organized these conversations sought to schedule them in a way that accommodated many Participants and tried to structure the sessions in a way that did not bring further harm to those affected by the mass casualty. They sought to strike a balance between hearing about the continuing impact of the mass casualty and the potential improvements to community safety. The conversations were transcribed and staff prepared a summary report for the Commissioners (see Annex B).

Stakeholder Consultations

The Commission facilitated eight stakeholder consultations with organizations across the province to discuss recommendations that could help make communities safer. In addition to giving us meaningful feedback, these consultations also provided a space for community organizations to discuss challenges and resource strategies with each other. If they continue to collaborate, they will build stronger networks through which to implement the Commission's recommendations for safer communities.

Our research and policy team and public engagement and communications team facilitated these virtual sessions to enable organizations throughout the province to discuss topics relevant to the Commission's mandate. Mental health support was available for those who required it during and after the meetings. Among the participants were SchoolsPlus, Boys and Girls Club Truro, Inspiring Communities, YWCA Halifax, Bridges Institute, Atlantic Policy Congress of First Nations Chiefs, IWK (Izaak Walton Killam Hospital for Children) Mental Health and Addictions, Engage Nova Scotia, Victorian Order of Nurses, Antigonish Women's Resource Centre and Sexual Assault Services, Along the Shore Community Health Board – NS Health, and Truro Housing Outreach Society. Most stakeholder consultations noted an overall decreased sense of community safety after the mass casualty.

In the stakeholder consultations about gender-based and intimate partner violence, participants discussed topics such as early education to break a culture of stigma, programs and support for boys and men, empowering women to navigate resources, and building community capacity and support networks. In consultations about early childhood and youth education on community safety, they discussed topics such as children having stronger networks of support and more opportunities to advocate for themselves, children feeling safer in schools, connecting youth with their communities by providing more opportunities to be involved, SchoolsPlus as an asset, and integrating more community safety into early childhood curriculum. In consultations about community safety in rural communities, they discussed the importance of addressing foundational community needs such as mental health, housing, food security, and other socio-economic contributing factors; integrating the police more into the community; and a strategic community safety plan built in collaboration with community members. In consultations about support services in rural communities, they focused on mental health support and investigating how these services could be made more accessible and timely.

The stakeholder consultations initiated conversations among organizations to facilitate networks, sharing ideas and future initiatives. Some of the challenges the Commission encountered in planning and carrying out these sessions included difficulties in scheduling different organizations and overlap where representatives wanted to attend multiple consultations. Commission staff also experienced some difficulties in shifting conversations away from existing challenges to potential solutions and improvements.

The stakeholder consultations were transcribed, and staff prepared a summary report for the Commissioners (see Annex B).

> Facilitated dialogue processes combined with subject matter expertise and experience encourage robust participation and learning.

Consultations with Organizational Participants

A consultation with organizational Participants during public proceedings.

The Commission designed consultations with organizational Participants in a way that encouraged organizations in the same sector to share their views and perspectives among themselves and with the Commissioners. We chose a dialogue format to help build understanding and to deepen insight on key issues the organizations identified. As with our Participation Decision, we grouped the organizations according to their purpose, focus, and characteristics as follows:

- victim advocacy organizations;
- health-related organizations;
- firearms organizations;

- justice organizations;
- gender-based organizations; and
- police-related organizations.

The Commission prepared questions to enable structured group discussions among Participant representatives. This additional input on key issues and potential avenues for reform would assist us in developing effective and meaningful recommendations related to our mandate. Participant organizations also made presentations and brief oral submissions during these sessions. The consultations followed our usual public proceeding format, similar to roundtables, and were webcast. Participant organizations that indicated an interest in issues relating to the police were also provided with the opportunity to play a role in the Phase 3 roundtables on community policing; the structure of policing in Nova Scotia; and police supervision, oversight, and accountability.

The Participant consultation with victim advocacy organizations focused on best practices for integrating a victim-centred approach into planning and preparation for critical incident response and for providing support services following a critical incident. This consultation included representatives from the RCMP H Division Victim Services, RCMP Contract and Indigenous Policing Vulnerable Persons Unit, Nova Scotia Department of Justice Victim Services, Canadian Resource Centre for Victims of Crime, and the Canadian Association of Chiefs of Police (National Working Group Supporting Victims of Terrorism and Mass Violence). It also included a presentation by Insp. Thomas Warfield and D/Cst. Helen Burton of the Peel Regional Police about an initiative by their Mass Casualty Bureau which involves setting up a 1-800 number where loved ones can call and report people missing during a mass casualty. Staff then attempt to make connections between missing persons (whether alive, injured, or deceased) and their families. This unit takes the pressure off 911, especially while a mass casualty is still unfolding. Cst. Danielle Bottineau of the Toronto Police Service then presented information about an initiative for training family liaison personnel.

Following these presentations, Participant representatives were invited to make submissions highlighting key principles for the effective integration of various victim-centred approaches and to take part in a structured group discussion. The discussion covered a range of topics, including the kinds of supports needed by individuals, families, first and second responders, and communities affected by a mass casualty; the role of communities and governments in designing and

delivering those supports; ways to incorporate a victim-centred approach to the provision of services; and best practices for providing support after a mass casualty.

The focus of the Participant consultation with gender-based organizations was twofold: the prevention of and non-carceral intervention in gender-based and intimate partner violence; and strategies to improve community safety and well-being, recognizing that they must be inclusive and attend to both the situation and the needs of vulnerable and marginalized individuals and communities. This consultation included representatives from Avalon / LEAF / Wellness Within, Women's Shelters Canada, Transition Houses Association of Nova Scotia (THANS), Be the Peace Institute, Feminists Fighting Femicide / Persons Against Non-State Torture, RCMP H Division Victim Services, and RCMP Contract and Indigenous Policing Vulnerable Persons Unit (Human Trafficking / Missing and Murdered Indigenous Women and Girls). It also included presentations by authors of two Phase 3 expert reports: Dr. Katreena Scott of Western University, who wrote "When We Know Something Is Wrong: Secondary and Tertiary Intervention to Address Abuse Perpetration"; and Nick Cardone of Free Range Therapy, co-author with Brian Braganza of "Conceptions of Masculinity and Violence Towards a Healthier Evolution of Men and Boys."

In the first discussion, on the prevention and non-carceral intervention in gender-based and intimate partner violence, Participants had the opportunity to share their perspective and specific suggestions on these topics. The Commission invited all Participants to engage in a dialogue about the challenges and barriers experienced in addressing gender-based and intimate partner violence and ways to overcome these challenges. This conversation was followed by a structured group discussion about the challenges to addressing these issues and suggestions for recommendations for countering them and included impact assessments and barriers to implementation.

Following the structured group discussion, Participants were invited to share their insights and suggestions about equality and community safety and well-being. We asked three questions to guide the conversation: What resources and supports do women, children, and other vulnerable people need to be safe and protected from violence? What is particularly needed in rural areas? What will make the biggest impact? Answers to these questions sometimes engaged policing strategies, but were not limited in scope.

The Participant consultation closed with a second structured group discussion, in which representatives considered what resources and supports women and children need to be safe and protected from violence, including what is particularly needed in rural areas. Representatives also shared their views about what service providers need to do or better understand in order to contribute to community safety in rural areas, and how to account for the needs of vulnerable or marginalized individuals and communities in designing and implementing responsive policies, programs, and interventions.

The Commission structured our Participant consultations with police-related organizations because many of the larger, systemic policing issues would be canvassed in our Phase 3 roundtables. We designed facilitation questions for the Participant consultation with police-related organizations to provide those organizational Participants with an opportunity to discuss other priority issues they had identified in conversations with the Commission.

The Commission invited representatives of the Truro Police Service, National Police Federation, Nova Scotia Chiefs of Police, Public Safety and Security Division of the Nova Scotia's Department of Justice, Department of Service Nova Scotia and Internal Services at the Government of Nova Scotia, and the RCMP (including the RCMP Veterans Association and H Division Planning) to our Participant consultation with police-related organizations. We began with a session about education and training, standards, and support for police officers. The conversation covered topics related to police workforce issues and ways to ensure that officers have the capacity and capabilities to perform and excel in fulfilling the important responsibilities entrusted to them. Part of the focus was on training and standards related to the Commission's mandate, including critical incident response, policing in rural communities, addressing gender-based and intimate partner violence, the identification of firearms and ammunition, and dealing with firearms complaints. A second focus was on access by members of police forces to the support services they need, particularly in the wake of a critical incident. This opening session was followed by a structured group discussion on the topics of wellness, education and training, and standards.

The second session focused on police resources in Nova Scotia, including financial and human resources, technical assets, and equipment issues, and the preparation and management of those resources for daily delivery of police services, including responding to a critical event. This session led into a structured group discussion around three core themes relating to human resources, equipment, and

co-operation among community safety partners, including government services, non-profit organizations, and neighbouring police services.

The Participant consultation with firearms organizations focused on the issue of access to firearms in Canada after the mass casualty. This session included representatives from the Canadian Coalition for Firearm Rights, the National Firearms Association, the Provincial Firearms Program at the Nova Scotia Department of Justice, the Coalition for Gun Control, and the Director of Firearms Policy at Public Safety Canada. Professor Joel Negin presented the expert report he and his colleagues wrote on "Firearm Regulation in Australia: Insights from International Experience and Research." Participant representatives were then invited to make submissions and share their insights on potential directions for regulatory and enforcement reform, and to participate in a structured group discussion that addressed questions such as how access to firearms should be regulated in Canada and how to enforce laws about the possession, importation, and transfer of firearms.

The Participant consultation with justice organizations included representatives from the British Columbia Civil Liberties Association, East Coast Prison Justice Society, and Nova Scotia's Department of Justice (represented by the executive director of public safety and security). This consultation recognized that justice organizations have experience working with marginalized persons and groups who have come into conflict with police as well as the wider justice system. Through this consultation, we sought to learn about connections between the invisibility and exclusion of marginalized groups and the causes, contexts, or circumstances of the mass casualty. The Commission asked Participant representatives to discuss institutional barriers to achieving structural change to policing and public safety in Nova Scotia, as well as the shortcomings of various models of legal oversight of police organizations. We also invited them to tell us what needs to change for police oversight mechanisms to succeed, and what is needed to better support non-carceral approaches to justice and community safety in Nova Scotia.

The Participant consultation with health-related organizations was intended to focus on the theme of improving community safety and well-being from the perspective of these organizations, which are an integral part of community safety networks. Topics were to include the provision of services to communities in the aftermath of the mass casualty, workplace safety, and the risk of violence for community workers, as well as perspectives on, and recommendations for, preventing gender-based and intimate partner violence. Unfortunately, because of planning and time constraints, the Participant consultation with health-related organizations was never held.

Participants should be invited to work with inquiry staff to identify key issues and the format of consultations about recommendations.

Small Group Sessions with Individual and Family Participants

The Commission held 15 small group sessions with family members of some of those whose lives were taken during the mass casualty of April 18 and 19, 2020, as well as with some of those who survived. From late August to late September 2022, we met, mostly in person, with 20 family members from 12 different families.

We had met with many family members in the spring and fall of 2021 to talk about the Commission process. During those meetings, we had undertaken to provide a future opportunity for them to share their views about the mass casualty directly with us. We were flexible in how we honoured that commitment, and it was challenging to develop the right format and find the right time. It is fitting that our process began and ended with meetings with this group of those most affected by the events of April 18 and 19, 2020. (A list of these meetings appears as Appendix R.)

The purpose of these small group sessions was to hear and learn from the experiences of family members and survivors as they sought information and gathered support during and after the mass casualty. The Commissioners needed this information to help them make meaningful and pragmatic recommendations to assist families involved in mass casualties in the future.

The small group session focused on three questions:

- What do you want to tell us about your experience seeking information and getting support during and immediately after the mass casualty?
- Which issues are most important to you for the Commission to focus on as we finalize our recommendations?
- Are there other things that would be important for the Commission to understand when it comes to your experience seeking information and getting support during and after the mass casualty?

We had intended to hear from family members and survivors in the small group session format in June 2022, timed to assist us in the context of Phase 2 activities addressing the post-event support part of the mandate. However, when the Commission held an information session for family members on May 10, 2022, to provide information about the proposed approach to the small group sessions, a group of family members voiced their concerns about the format and framing of the intended sessions. A lengthy consultation process followed, in which several Participants met with Commission staff and expressed their desire to meet with the Commissioners at a later time and in a more private setting. Some were strongly opposed to having their sessions webcast. Others were unwilling to meet with any other families present. Eventually we scheduled a series of sessions in late August and throughout September.

As requested, we met with family members as individual families, rather than hosting different families in the same session. Family members could appear in person, in Truro or Halifax or via online video, sharing as much or as little as they wished and taking breaks as needed. Given the opposition of some families to having the meetings in public, the meetings were not part of the live broadcast public proceedings. To meet the Commission's legal requirement of transparency, staff made an audio recording of each session. Transcripts from the sessions were made available in English and in French and posted to the Commission website as public documents. Commission staff facilitated the sessions, which were each scheduled for an hour. Participant counsel and a support person could attend at the discretion of each of the families, but did not have a speaking role during the session. Unfortunately, the recording of our session with Clinton Ellison and Connor Reeves had been overwritten before it was saved, and Commission and technical staff exhausted all efforts to recover it. Commission counsel contacted counsel for Clinton Ellison and Connor Reeves to extend an apology on behalf of the Commission. Although there is no transcript, the Commissioners listened carefully during the session and learned from the information that was shared.

The facilitated conversations focused on the systems that serve families during mass casualty events, the supports and services that were most helpful to families, and the gaps and challenges that need to be addressed. Family members were invited to share their perspectives on any topic they wished, and the sessions addressed post-event communications with families, next of kin notifications, mental health supports and services, the role of family liaison officers, post-event logistics, and support from medical examiners and victim services.

Overall, the sessions were very constructive, and attendees used the opportunity to share their experiences and expectations, sometimes with deep emotion. Some Participants also shared their criticisms of the Commission process and our decisions and actions as Commissioners. Each session was unique, and they all made an important contribution toward helping the recommendations from this Commission be meaningful, people-oriented, and effective.

Issue-Based Consultations with Individual and Family Participants

The Commission's issue-based consultations with individual and family Participants provided those most affected with a further opportunity to meet with the Commissioners to discuss potential recommendations about particular issues they had identified as priorities. This invitation for Phase 3 consultation came in addition to the opportunity for formal written and oral submissions by Participants' counsel at the close of the Commission's public proceedings. We believed it was important to provide a less formal opportunity for the sharing of views and perspectives, and these sessions were open to individual and family member Participants who wished to share their thoughts on the broader issues related to our mandate.

The small group sessions focused initially on personal experiences during and immediately after the mass casualty and then broadened to discuss recommendations. In these sessions, the discussion focused on issues rather than experience. Some Participants chose to participate in both a small group session and the group consultation, some chose one or the other, and others declined to participate in these Phase 3 activities.

A guiding purpose of these consultations was to hear from those most affected about what they considered to be the priority issues for the Commission as it developed recommendations that could help respond to and prevent similar incidents in the future. For example, some family members wanted to provide their perspectives on firearms or emergency alerting and other public communications from first responders. We welcomed a conversation with interested individuals to develop a consultation mechanism that suited their expressed interests.

Although the format and agenda for these consultations depended on the interests identified by individual and family Participants, we anticipated that these sessions would be organized on issues central to the Commission's mandate. In

consultation with those most affected and their counsel, the Commission drafted a list of topics and prompts to guide these conversations. The topics were about ensuring public communications during an emergency; supporting individuals, families, first responders, and communities after a mass casualty; preventing gender-based and intimate partner violence; regulating access to firearms; regulating police paraphernalia; improving community safety and well-being; changing our current structure and approach to policing; and the challenges of implementing change.

We hosted two sessions to consult with individual and family Participants, and both were held in Truro. At one session, some people attended virtually. The sessions were not open to the public and were not webcast. The Commission produced transcripts for each session, and they are available as part of the public record. The following table describes the range of Phase 3 activities of the Commission.

Phase 3 Activities

Activity	Audience	Objective	Access
Public submissions	Any interested person	To provide the public the opportunity to share suggestions for relevant research and for potential changes they would like to see implemented to make their communities safer, as well as recommendations they wanted us to consider.	All submissions were reviewed internally, sorted into categories, and provided to the Commissioners for consideration.
Consultative conferences	Individuals or groups that may have been differentially affected by the mass casualty	To provide an opportunity for the Commissioners and the Participants to hear from representatives of these communities about potential recommendations, including how best to ensure that their distinctive strengths and experiences were fully and respectfully factored into the Commission's recommendations on matters within its mandate.	Webcast as part of public proceedings.
Community conversations	Members of the following communities: Great Village, Onslow, Debert, Millbrook, and Truro, employees of the VON	To provide the Commission with local community perspectives on how the mass casualty affected feelings of safety and to gather lessons learned from the mass casualty in different communities.	The conversations were transcribed and staff prepared a summary report for the Commissioners.

Activity	Audience	Objective	Access
Stakeholder consultations	Key stakeholder organizations across the province	To discuss recommendations that could help make communities safer. In addition to giving us meaningful feedback, these consultations also provided a space for community organizations to discuss challenges and resource strategies with one another.	The stakeholder consultations were transcribed, and staff prepared a summary report for the Commissioners.
Organizational Participants consultations	Organizational Participants grouped according to their purpose, focus, and characteristics	To gain additional input about key issues and potential avenues for reform, to assist the Commissioners as they developed effective and meaningful recommendations through structured group discussions among Participant representatives and Participant presentations and brief oral submissions.	Webcast as part of public proceedings.
Issue-based consultations with individual and family Participants	Individual and family Participants	To provide those most affected with a further opportunity to meet with the Commissioners to discuss potential recommendations about particular issues they had identified as priorities. Discussions focused on issues rather than experience.	The sessions were not open to the public and were not webcast. The Commission produced transcripts and made them available as part of the public record.

Close of Proceedings and Shift to Report Writing

The Commission hosted our final week of public proceedings in Truro in late September 2022. We had been scheduled to hear the Participant final oral submissions from September 19 to 22. Unexpectedly, the government announced a public holiday to mark the funeral of Queen Elizabeth II on September 19. Fortunately, Commission staff were able to secure the venue in Truro for an extra day, September 23, which turned out to be the day that Hurricane Fiona was forecast to blast into Nova Scotia. Though it did not arrive until that evening, it caused a sizeable amount of contingency planning and urgency in finishing our proceedings as early as possible. On the morning of that last day of an inquiry that had focused considerable attention on public alerting, everyone present received a public alert on their cellphones warning of the coming storm. Hurricane Fiona proved to be an extreme weather event. Many of the communities that were most affected by the mass casualty suffered further damage in the storm.

Participants made their final oral submissions from September 20 to 23. On September 23, 2022, the last day of the public proceedings, we Commissioners delivered our closing remarks.[70] Given this milestone, we decided to share how far we had come together, what we had learned along the way, and what would come next.

From the outset, we faced an immense task, a very broad mandate, and an ambitious timeline requiring us to complete our work in just over two years. We explained that we had designed a process that enabled the Commission to be flexible and efficient – to investigate, to subpoena witnesses and documents, and to explore the broader root causes of the April 2020 mass casualty through wide-ranging work grounded in research and policy. Our approach allowed the different phases of our work to overlap while also building on each other. In all, we produced 31 Foundational Documents, interviewed more than 250 people (including 80 police officers), heard from 60 witnesses (including RCMP members, first responders, experts, and community members), and organized 21 roundtables involving over 100 experts and 22 commissioned reports.[71] We acknowledged the integral role of the Participants in the three phases of the inquiry process. We also expressed our gratitude to the 900 members of the public who shared their experience of the mass casualty through our online survey. We recognize the time and

commitment that all of these people put into the Commission work and the resulting benefit to the public interest.

We explained that we were now focused on preparing the Final Report, which would include clear, pragmatic, and achievable recommendations based on everything we learned about what happened on April 18 and 19, 2020, and how and why it happened. The recommendations would enable people in our governments, institutions, and communities to begin to take action immediately after the release of our Final Report, which we indicated was scheduled be shared with the public, in English and in French, by March 31, 2023.

Although our substantive public proceedings concluded on September 23, the Commission's Phase 3 work continued until the end of September 2022, as we held consultations with stakeholder groups and in affected communities to canvass input for potential recommendations. Commission staff conducted these additional meetings in small settings with people directly affected by the mass casualty and also community members.

We scheduled one final day of virtual public proceedings on October 27, 2022, as an opportunity for the Commission to mark a significant number of documents (over 2,000) as exhibits. We had received some late disclosure from the Attorney General of Canada and the RCMP. In addition, some Participants wished to mark as exhibits materials they relied on in their final written submissions; and Commission teams that had reviewed some documents retroactively wanted to ensure that a complete record would be available to us for the Final Report. We received one further affidavit and two pieces of correspondence that were too late to include on October 27. We also determined that further correspondence, an interview transcript, and an intelligence assessment should be marked as exhibits. We issued orders administratively marking these documents as exhibits (Appendices I-7 to I-11).

Although we had not received everything we had sought by subpoena by the close of public proceedings, and indeed had to schedule one further witness interview with C/Supt. Chris Leather on the last day of public proceedings to follow up on issues arising from late disclosure, we had to end document production on October 4 in an effort to provide Participants with the full record in time for their final written submissions. Initially their written submissions were due in late September, but then we moved the date for final written submissions to October 7, with reply submissions due October 28. We also agreed to receive submissions specific to late disclosure until November 14, 2022, in an effort to be fair, given the volume

of late disclosures. We cancelled access to Relativity, the document database, on November 30, 2022, for all licensees except for the report writing team.

By September, drafting of the report was well underway, but the entire focus of the Commission shifted to report writing once the public proceedings closed. We had a massive amount of material to review, analyze, and weigh, and we had important decisions to make about recommendations. The entire draft had to be written and agreed upon, with editing, layout, accessibility coding, and translation to occur on a rolling basis in order to release the complete report by March 31, 2023.

Preparation of Report: Extension Request

In August 2022, the Commission requested and received approval from both the provincial and the federal governments for an extension to submit our Final Report by March 31, 2023, instead of November 1, 2022. At the time of our request, the Commission was still on track to complete our public proceedings by the end of September 2022 as planned, and we did not request any additional funding to accommodate an extension. The extension request applied only to the writing of this Final Report. We had a number of reasons for our request:

- The mandate set by both the federal and provincial government was broad, with a tight timeline from the beginning.
- We adjusted the start of public proceedings multiple times to allow Commission staff and Participants more time with the documents. We knew that even with the changes to the schedule, they had an enormous amount of work to do in a short time.
- COVID-19 restrictions delayed community outreach and affected our teams, including our investigations team's ability to be in the communities most affected.
- Many of the tens of thousands of documents we received through disclosure were disorganized, without clear labelling, and received on a rolling basis. Some documents arrived only the week before we submitted our extension request.

- The pace, unpredictability, and volume of document disclosure severely affected the Commission's ability to meet timelines and progress our work in a timely way.

The additional time allowed us to complete our Final Report with the care and attention it deserved. We wanted to ensure that this process was thorough and that the Report and our recommendations are beneficial to all Canadians, particularly as they will help to improve community safety across our country.

CHAPTER 5

Recommendations Related to Future Public Inquiries

In this chapter, we provide some recommendations for future commissioners and for the governments appointing them.

Considerations When Starting an Inquiry

Here, we offer two main recommendations: that (1) proposed commissioners be consulted before the inquiry is called, and (2) the commissioners, once appointed, be afforded an opportunity to prepare before its official work begins.

Recommendation Pr.1

PRE-INQUIRY PHASE

The Commission recommends that there should be a consultation phase prior to the establishment of an inquiry. During this phase, governments should identify the commissioner(s) and, pursuant to an appropriate confidentiality undertaking, engage them in discussion about the draft terms of reference in order to ensure the mandate is realistic.* In particular, the scope of the mandate must be achievable in the time frame allotted.

* There is precedent for such discussions. For example, in the Arar Inquiry, Commissioner Dennis O'Connor with his counsel Paul Cavalluzzo negotiated the mandate (see Bessner and Lightstone, *Public Inquiries in Canada: Law and Practice* (Toronto: Thomson Reuters, 2017), 28–29 and 77–78).

We also encourage governments to provide clarity about the powers of the inquiry while ensuring it has as much flexibility as possible. Such clarity could assist others to address a challenge we faced in which we were limited by a provision of the Orders in Council (discussed in Chapter 2, above) directing us not to interfere with any ongoing criminal investigations. This provision proved difficult because we did not know what investigations were underway and what charges were potentially forthcoming. This uncertainty held up some of our work and consequently fed a public narrative that our process could be manipulated simply by the laying of charges.

Inquiries require a significant expenditure of public funds, and there needs to be an understanding of what is involved to create and build a temporary institution so that it will be accountable for those public funds. Not only will having a brief pre-inquiry phase be an efficient way to avoid delays later on, but it will also create a better understanding of what is required in the Order in Council and what is required for the independence of the inquiry. A preliminary opportunity to collaborate about appropriate timelines and sufficient resources would, in the long run, bolster the commission's independence. At the same time, nothing would prevent a government from announcing its intention to establish a commission of inquiry and that preliminary steps are underway.

Recommendation Pr.2

PREPARATORY PHASE

The Commission recommends that following this brief pre-inquiry phase, the Orders in Council should provide for a three-month preparatory phase to allow the commissioners time to (a) establish appropriate infrastructure such as office space, computers, and phones, (b) develop a website, and (c) hire start-up support staff. Only then should the mandate clock start ticking toward the due date of the final report.

During this preparatory phase, the commissioner(s) could also establish their vision for accomplishing the mandate. They could then engage in planning to determine how they might direct their vision and how to track the associated work along the available timelines. Such planning would enable commissioners to

clearly assign roles and responsibilities to their staff and effectively communicate expectations from the outset.

Given the fast pace that all inquiries experience, future commissioners would also benefit from having a senior resource person such as a chief operating officer dedicated to coordinating day-to-day work, improving communication and collaboration across the teams, tracking the timelines, and ensuring that decisions made are implemented. Working in conjunction with the executive director / chief administrative officer, the chief operating officer could also seek additional resources as needed throughout the course of the Commission's work.

> Among the earliest of hires to support the work of a public inquiry, these three positions are key to its success: (1) communications and public engagement director, (2) chief administrative officer, and (3) chief operating officer.

Some upfront work will help a commission determine what kind of structure to adopt. Different commissions are structured in different ways, leading to different outcomes and experiences. This variance starts from the number of commissioners appointed and extends to such things as how teams are organized. Running an inquiry requires the ability to work efficiently and effectively, setting up work teams quickly, and telling them to sprint while integrating new members along the way. Having the opportunity for advanced planning before the public-facing work (particularly for a multi-jurisdictional inquiry) begins would pay dividends and help build public confidence once the outward-facing work starts.

An inquiry is an inherently indeterminate process that depends, for example, on the nature of the mandate, the approach taken by the commissioner(s), the number of participants, and the time allotted to complete the mandate. For this reason, the process needs to be agile from the outset, adapting to the complex and unforeseen factors that inevitably cause delays. Such a preparatory phase would help future inquiries avoid the need to seek extensions.

In this Inquiry, we engaged in intensive planning exercises early in 2021. In these planning sessions, we identified the various components of the work, general roles and responsibilities of staff, and intended timelines. The sheer pace, volume, and demands of the substantive work, however, soon overtook the planning phase. The experience then became one of "building the plane while flying it." Considerable

structural supports are necessary to plan and run a public inquiry, without which risks arise around communication, role confusion, duplication of effort, and, potentially, the need for extensions. Such issues could be avoided with some advance time for commissioners to study the mandate, obtain wise input, and plan and set up the infrastructure necessary to do the fast-paced and complex work to follow.

Considerations for Document Production

Document production is not a novel process; it is repeated with considerable regularity. As described in Chapter 4, the manner in which disclosure was received caused significant additional time and cost owing to increased staffing required to organize, review, and manage the materials. The problems we encountered are not limited to the RCMP and the Attorney General of Canada, but are endemic to large and complex institutions when engaged in any process requiring document disclosure. The pervasive and massive scale of disclosure challenges represents an inordinate amount of work and public expense. Delays in full and timely disclosure affect the fair administration of justice. This ongoing challenge merits a comprehensive solution that recognizes the collaborative as opposed to adversarial nature of inquiries. We direct the following recommendations to the Attorney General of Canada, although provincial and territorial Attorneys General might also wish to adopt them.

Here we make three recommendations: that the Attorney General of Canada (1) perform an external independent audit and (2) create a designated document disclosure body. We also recommend that (3) the government establishing the inquiry give commissioners the ability to direct how documents should be produced. Finally, we present some suggestions about improving everyday document management and offer some guidance to institutions for when an inquiry is called.

Recommendation Pr.3

EXTERNAL INDEPENDENT AUDIT

The Commission recommends that an external independent audit of the RCMP and the Attorney General of Canada's document management and production processes be conducted, with the results made public.

This informational audit would provide a sense of the scope of the problems by looking at internal processes and analyzing such aspects as whether and how privilege reviews are conducted, and whether best practices of document management were followed. An external independent audit would provide insight into the degree to which the issues may have arisen from RCMP internal structures and processes or from those within the Department of the Attorney General. The audit could then provide a set of best practices.

Recommendation Pr.4

DESIGNATED DOCUMENT DISCLOSURE BODY

The Commission recommends that the federal government create a designated body to assist the Attorney General of Canada with document disclosure generally.

Document disclosure is complicated and expensive and the obligation occurs repeatedly, whether through inquiries, class actions, or other legal mechanisms that involve government actors. One dedicated body could develop the appropriate systems and expertise that would enable greater efficiency and consistency.

A designated document disclosure body would address the problems experienced by a variety of parties seeking disclosure and help prevent accusations of bad faith against government agencies. Such a body would understand the different context of a class action or other litigation and a public inquiry for the purposes of disclosure. The body would be mandated to handle production for any process in which the government is immersed and would achieve an economy of scale by

preventing a reinvention of the wheel each time production is required. This body would be proficient in current document management technology.

Recommendation Pr.5

FORM OF DOCUMENT PRODUCTION

The Commission recommends that public inquiries should be authorized to direct the manner in which participants must produce documents in their possession.

To improve efficiency, inquiries for example should be able to require participants to produce documents in one delivery or to produce intact original electronic documents in their original format. This power should be achieved through legislative amendment to the relevant statutes governing inquiries, or, failing that, this authority should be included in the Orders in Council establishing an inquiry.

In any event, institutions holding material documents should immediately, upon a public inquiry being called, take steps to ensure staff fully understand the scope of the inquiry, the types of documents that are likely to be requested, and that they should expect subpoenas for their documents and potentially for their testimony. Preparing to provide this information early, in good form so that the process can be as effective as possible, will assist everyone involved.

Further Considerations

In addition to the above recommendations, we would like to make the following general suggestions.

Improving Everyday Operations

Another part of enhancing disclosure lies in improving the everyday operation of document retention and management systems by government departments and agencies. Strengthening routine operations would enable everyday practices to be scaled up when bigger things such as inquiries come along. As noted above, some of the disclosure challenges emanate from a flawed understanding of what an inquiry is and the responsibility of full disclosure. There is a *higher* duty to produce documents for an inquiry than in a litigation context. This duty is not well understood by the legal profession, which is inherently adversarial. Therefore, a cultural shift is required in addition to improved systems. Such a shift can be achieved through leadership that sets up practices and protocols in line with the public interest.

Guidance When an Inquiry Is Called

In addition to the everyday changes that can improve response in the event of an inquiry, we suggest that whenever an inquiry is established, the subject institution and the Attorney General should take these steps and approaches:

1. Recognize that a public inquiry is not another litigation file; it should entail a separate budget from general litigation files for the relevant departments to properly participate.
2. Set up a process by which management and members of the subject departments / institutions, and their legal counsel, are briefed on what to expect. In particular, they should be aware that a public inquiry is obligated to act in the public interest. It cannot make determinations of civil and criminal liability, so the subject institutions should be prepared to provide more in the way of disclosure than with a litigation file.
3. Prepare management and staff members to understand the scope of the inquiry, to be aware of the types of documents that are likely to be requested, and to expect subpoenas for both their documents and their testimony. An awareness of the importance of preparing to provide this information early and in good form, so that the process can be as effective as possible, will assist everyone involved.

CHAPTER 6

Expenditures

CHAPTER 6 Expenditures

Both the media and the public expect inquiries to be transparent and independent, including with respect to their expenditures and the cost of the inquiry. This expectation presents a number of challenges because the costing for inquiries is multi-faceted. In our case, the Commission is a joint inquiry, so costs are shared by the province of Nova Scotia and Canada and are subject to both their fiscal reporting schedules.

Each commission is unique, so it is not easy to make cost comparisons or set any expectations. Although the mass casualty took place in Nova Scotia, our mandate had a national scope as recommendations, particularly around the RCMP and community safety, would have national impact. There are a number of factors in inquiry costs, including the cost of legal counsel for Participants – an important aspect of inquiries to ensure that individuals and groups with substantial and direct interest can participate without any financial barriers. The number of proceeding days, scope of the mandate, and staff required to complete the mandate in the allotted time frame are also key components. So, comparing our work or costs to that of the Desmond Fatality Inquiry (2018)[1] or even the Commission of Inquiry into the Westray Mine Tragedy (1992)[2] (not considering the significant time that has passed) does not provide accurate comparisons. Despite the significant task outlined in our mandate and the obstacles created by the COVID-19 pandemic, the Commission's costs were in line with past inquiries of similar size and scope. Inquiries of similar scope and size would be more along the lines of the Commission of Inquiry into the Sponsorship Program and Advertising Activities (2004; also known as the Gomery Commission),[3] or the Commission of Inquiry into the Investigation of the Bombing of Air India Flight 182 (2006).[4]

The Commission worked with the Privy Council Office to forecast inquiry expenses by fiscal year, providing a detailed project roadmap to facilitate financial planning and approvals. The Commission's expenditures complied with the *Financial Administration Act*,[5] including federal government rules concerning procurement

of goods and services. All travel costs for Commission staff and for Participants and their counsel were subject to federal government travel directives. The Commission released its expenditure update for the fiscal years 2020/21 and 2021/22. We posted an expenditure update on our website, which included a breakdown of expenditures from the beginning of the Commission's mandate (October 21, 2020) until the end of fiscal 2021/2022 (March 31, 2022) (see Appendix S). We were committed to posting a breakdown of expenses on our website as they became available from government, and all expenditures will be reported as a matter of public record once our work is complete.

CHAPTER 7

Conclusion

CHAPTER 7 Conclusion

Over approximately 13 hours, from Saturday night April 18 to Sunday morning April 19, 2020, a man, whom we refer to as the perpetrator, shot and killed 22 residents of Nova Scotia, one of whom was expecting a child. He also shot and wounded two more people before being killed by RCMP officers in the ensuing manhunt. His rampage extended through several communities in the central part of the province. In addition to these gun-related deaths and injuries, many other types of harms are associated with this rampage, and we chose the broader term "mass casualty" to encompass them all.

We began our work on this Commission with the priority of meeting with those most affected and consulting with others who could assist us to design an effective public inquiry. We have continued throughout our work to seek to foster collaboration with the public, with stakeholders, and among our own staff members. We embraced the fact that we led a *public* inquiry, and we recognized the importance of public confidence and engagement in our work.

We underscore that the word "public" is of equal importance to "inquiry." We believe that our ability to carry out our mandate successfully depended on engaging the public in the two inseparable parts of our work:

- developing an evidence-based account of what happened, and how and why; and
- devising forward-looking recommendations for reforms that will help to prevent and respond to future incidents.

This engagement was a two-way street. We counted on members of the public to provide us with information and views. We also sought to give people adequate information on which to form a knowledgeable opinion about what happened; and we wanted to shift away from the desire to assign blame to a more constructive

consideration of how to try to prevent and to respond to similar events in the future.

It is you, individual members of the public and civil society groups, who have helped us to prepare the best possible report. Our work has ended, but yours will continue. Only you can continue to hold governments and institutions to account, to ensure that our findings become lessons learned and acted upon.

For this reason, we conclude this volume of our Final Report with a call for continued engagement from all of you. As we share this Final Report and mark the end of our mandate, it is up to all Canadians – including policy-makers, first responders and service providers, public institutions, community groups, and members of the public – to take up our recommendations and make them into concrete actions to keep our communities safer across the country. You helped us to develop meaningful, practical, and sustainable recommendations for the future. It is time now to implement them.

Acknowledgements

The people of Nova Scotia, Canada, the United States, and beyond were shocked, horrified, and saddened by the mass casualty. Yet, while sorrow rippled outward from the affected families and communities, so too did kindness, compassion, and a shared willingness from many people to step up and help us in our work.

We acknowledge that with our work in Nova Scotia, we were guests in Mi'kma'ki, the ancestral and unceded territory of the Mi'kmaq. We are grateful for the presence and support of Mi'kmaw Elder Marlene Companion throughout the Inquiry proceedings.

We thank the families of those whose lives were taken for meeting with us and sharing tributes to your loved ones, along with your thoughts and experiences. We continue to extend our deep and lasting condolences for your losses, and we share your dedication to making our communities safer in their memories.

Thanks too to all the Participants and your counsel. You played a critical role, putting in long hours outside of proceedings and being with us during the many long days and weeks of public proceedings. We remain struck by the way all Participants, particularly family Participants, looked out for each other during public proceedings. It was inspiring to see.

We acknowledge all the responders who answered the call to serve during and after the mass casualty. Whether you are with the police, firefighters, or emergency health or other civilian service providers, we appreciate your courage and ongoing commitment to keeping people safe and helping them in times of hardship.

Through interviews and proceedings, we heard from many witnesses and others who added to our understanding. We know it remains difficult for many to revisit the days during and after the mass casualty. Many of you spoke through tears, sharing important information that was often against your own interests or those of your employers. Your recollections about what happened and perspectives on

potential causes and recommendations have been instrumental to our work, and we deeply appreciate them.

We also heard from well over a hundred individuals who took part in the roundtables, small group sessions, consultations, and other conversations. You brought an incredible depth and breadth of expertise and experience to our work, shedding light on large and complex issues and helping us gather lessons learned and potential recommendations – including helping us think about making sure the final recommendations do not have disproportionate or unintended impact on disadvantaged or marginalized groups.

Thank you to the community organizations who met with the Commission team and helped us do our work in your communities, providing much needed supports and connecting us with necessary people and information. Additionally, virtually every counsellor or counselling service in Nova Scotia contacted signed up to help through the Criminal Injuries Counselling Program to provide support.

Thanks also to members of the media who have covered the Commission's progress including public proceedings, helping the broader public stay engaged with our work. We acknowledge you had to contend with difficult information day in and day out, and we applaud your commitment to openness and transparency, and to getting answers to difficult questions.

Our work would not have been possible without the assistance of many service providers. You helped to make our investigation and proceedings accessible to as many people as possible, assisting us with document management, technology, webcasting, French / English translation, sign language interpretation, transcription, security, and many other services.

Thanks to the public in Nova Scotia, in the rest of Canada, in the United States, and beyond for your engagement and for taking part in our work. We are grateful to those of you who were able to join us in person at proceedings, those of you who attended the open houses, and all of you who have engaged online, sent us emails, or called.

We also benefited from the important work of past inquiries as well as the wise advice generously offered by previous commissioners and inquiry staff.

The spirit of public service shone brightly in the Commission team. We chose you for your experience, expertise, and professionalism. Yet we also sought and found in all of you the intangible quality of commitment to public service. We asked

you to do your best, and you delivered. You answered the call to help others and to make a difference so that all the lives taken and suffering endured would not have been in vain. You dedicated more than two years of your life in very difficult circumstances to do right by all those affected. Thank you for bringing your inquisitive minds and caring hearts to work every day. (A list of Commission team members appears as Appendix T.)

To secure our independence, we had to recruit many team members from outside Nova Scotia. You came during the height of the COVID-19 pandemic, during lockdowns, which often forced you to isolate for weeks upon arrival, and in reverse you isolated for weeks on the rare occasions you returned home.

Those of you from Nova Scotia also faced challenges, navigating public health restrictions and the trials that came with the pandemic, followed by the broad impacts of Hurricane Fiona. You also performed your tasks while immersed in the constant sorrow that permeated your communities.

Whether from Nova Scotia or beyond, we thank all Commission team members. No matter the hour of day, night, or time zone, or what might have already been on your plate, you always said a willing “yes” to our requests. While nothing can compare to the sorrow experienced by those families and communities directly affected, your work was arduous, intense, and often painful. It involved dealing with graphic content, difficult material, and many heavy responsibilities. Not only was it a challenging journey for you; it affected your families and friends who surrounded and supported you. We thank all of them as well.

Although the Commission’s work has ended, we hope our findings and recommendations will have a longstanding positive and constructive impact, helping to make communities safer. All of you contributed to this work in meaningful ways, and we were honoured to be on this journey with you.

To each and every one of you, we express our heartfelt appreciation and offer our sincere thanks.

Notes

CHAPTER 1

Introduction: Purpose of the Process Volume

1. *Canada (AG) v Canada (Commission of Inquiry on the Blood System)*, [1997] 3 SCR 440; *Phillips v Nova Scotia (Commission of Inquiry into the Westray Mine Tragedy)*, [1995] 2 SCR 97.
2. Ronda Bessner and Susan Lightstone, *Public Inquiries in Canada: Law and Practice* (Toronto: Thomson Reuters, 2017) [Bessner and Lightstone, *Public Inquiries in Canada*], Chapter 3, and the sources therein; S. Goudge and H. MacIvor, *Commissions of Inquiry* (Toronto: LexisNexis Canada Inc., 2019), 160–69, and the sources therein.
3. Order in Council, Government of Canada, October 21, 2020 (Appendix A-1); Order in Council, Government of Nova Scotia, October 21, 2020 (Appendix A-2).
4. See Bessner and Lightstone, *Public Inquiries in Canada*, 8–9, 195–221; see also *Dixon v Canada (Commission of Inquiry into the Deployment of Canadian Forces to Somalia) [1997] 3 FC 169;* 149 DLR (4th) 269 (Fed CA), leave to appeal refused (1998), 226 NR 400 (SCC) at para 14.
5. Ontario, Report of the Elliot Lake Commission of Inquiry, Part Two: *The Emergency Response and Inquiry Process* (Ontario: Minister of the Attorney General, 2014) (Paul Bélanger, Commissioner), 439.
6. See, for example, *Phillips v Nova Scotia (Commission of Inquiry into the Westray Mine Tragedy)*, [1995] 2 SCR 97, at paras 116–18.
7. The Participation Decision can be found at Appendix D. The public update and remarks are reproduced in Annex A.
8. As noted elsewhere in this report, our independence was challenged on a number of occasions, including by the premier of Nova Scotia. However, we remained steadfast in resisting all and any attempted undue influence.
9. Bessner and Lightstone, *Public Inquiries in Canada*, 85.
10. See federal *Inquiries Act*, RSC 1985, c I-11, s 7 and s 8 and provincial *Public Inquiries Act*, RSNS 1989, c 372, s 4 and s 5.

CHAPTER 2

Establishing the Mass Casualty Commission

1. *Inquiries Act*, RSC 1985, c I-11, ss 7–8; *Public Inquiries Act*, RSNS 1989, c 372, ss 4–5.
2. The third individual, the Hon. Anne McLellan, declined the appointment when the governments converted the independent review to a public inquiry.
3. Federal *Inquiries Act*, RSC 1985, c I-11.
4. Nova Scotia *Public Inquiries Act*, RSNS 1989, c 372.
5. Examples include: Nova Scotia, Restorative Inquiry – Nova Scotia Home for Colored Children, *Journey to Light: A Different Way Forward – Final Report of the Restorative Inquiry – Nova Scotia Home for Colored Children* (Nova Scotia: Province of Nova Scotia, 2019), 1; Ontario, Motherisk Commission, *Harmful Impacts: The Reliance on Hair Testing in Child Protection* (Toronto: Ministry of the Attorney General, 2018) (Judith C. Beaman, Commissioner), ix; and Canada, National Inquiry into Missing and Murdered Indigenous Women and Girls, *Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls* (Marion Buller, Chief Commissioner) (Canada, June 2019) [National Inquiry into MMIWG, *Reclaiming Power and Place*], 1.
6. See, for example, Barbara Tomporowski, Manon Buck, Catherine Bergen, and Valarie Binder, "Reflections on the Past, Present, and Future of Restorative Justice in Canada" (2011) 48:4 *Alberta Law Review* 815, 2011 CanLIIDocs 149. Note that restorative principles underlie the restorative approach to justice that has been implemented in connection with the criminal justice system in Canada. The principles are not limited to the criminal justice context and underlie a restorative approach with broader and adaptable applications to a range of contexts.
7. For example, in schools, in the youth criminal justice system, and in the human rights complaint resolution process adopted by the Nova Scotia Human Rights Commission.
8. See, for example, Jennifer A. Leitch, "Lawyers and Self-Represented Litigants: An Ethical Change of Role?" (2017) 95:3 *Canadian Bar Review* 669, 2017 CanLIIDocs 238.
9. Decision with respect to proposed witnesses by Participants relating to the Portapique Foundational Documents, March 9, 2022 (Appendix I-1), para 38; see also the discussion under the heading "Phase 1 Public Proceedings."

CHAPTER 3

Designing the Inquiry

1. See Commission staff list in Appendix T. Short biographies of some Commission team members are provided on our website: https://masscasualtycommission.ca/about/commission-team/.
2. Bessner and Lightstone, *Public Inquiries in Canada*.
3. Nova Scotia, Desmond Fatality Inquiry (2018), online: https://desmondinquiry.ca/index.html.
4. *Personal Information Protection and Electronic Documents Act*, SC 2000, c 5.
5. *Freedom of Information and Protection of Privacy Act*, SNS 1993, c 5.
6. *Privacy Act*, RSC 1985, c P-21s.
7. Expenditure Update Fiscal Years 2020/21 and 2021/22 (Appendix S).
8. Participation Decision, May 13, 2021 (Appendix D-1) at paras 31–38.
9. Ibid at para 37.
10. See Participation Decision Addendum III, November 26, 2021 (Appendix D-4) and Participation Decision Addendum V, May 20, 2022 (Appendix D-6).
11. The Red Hill Valley Parkway Inquiry addressed a similar concern in February 2020. The municipal inquiry, established in 2019, received applications to participate from two individuals who were personally affected by tragic accidents on the Parkway, a highway near Hamilton, Ontario, as well as from a group of lawyers pursuing a class action against the City of Hamilton related to motor vehicle accidents on the Parkway. In denying these applications, Commissioner Wilton-Siegel highlighted the distinctions between groups of injured victims, whose involvement in related lawsuits gives them (or their counsel) a financial motivation to push for certain findings, and groups of concerned citizens, who bring the perspectives of affected communities to the issues before an inquiry and often complement the impartial role of commission counsel. Commissioner Wilton-Siegel further questioned whether the dual responsibilities of law firms that seek to involve themselves in both processes "could result in the Inquiry being used to further interests other than the investigatory and truth-seeking mandate of the Inquiry, or that the scope and mandate of the Inquiry could be distorted." Reasons and Decision Concerning Participation and Funding (February 12, 2022) at para 77; online: http://rhvpi.ca/li/pdf/RHVPI_Decision_on_Participation_and_Funding_February_12.2020.pdf .
12. Rules of Practice and Procedure (Appendix C).
13. Ibid at s 3.
14. Rules on Participation and Funding (Appendix B), s 5.
15. Rules of Practice and Procedure (Appendix C), s 11.
16. Ibid at s 25.
17. Ibid at ss 26–30.
18. Ibid at s 52.
19. Ibid at s 68.
20. *Inquiries Act*, RSC 1985, c I-11.
21. Ibid at s 13.

22. *Attorney General v Canada (Commissioner of the Inquiry on the Blood System)*, [1997] 3 SCR 440, at paras 38 and 39.
23. Ibid at para 40.
24. See Rules of Practice and Procedure (Appendix C).
25. Order in Council, Government of Canada, October 21, 2020 (Appendix A-1); Order in Council, Government of Nova Scotia, October 21, 2020 (Appendix A-2).
26. See sample Update from the Commissioners in Annex A.
27. Social Media Guidelines are reproduced in Annex A.

CHAPTER 4

Our Work: Three Phases

1. The Report of the Coroner's Investigation Concerning the Massacre at l'École polytechnique de l'Université de Montréal (1991), online: https://www.diarmani.com/Montreal_Coroners_Report.pdf.
2. See Jude McCulloch and JaneMaree Maher, "Understanding the Links Between Gender-Based Violence and Mass Casualty Attacks: 'Private' Violence and Misogyny as Public Risk" (2022) in Annex B.
3. See Barry MacKnight, "Structure of Policing in Nova Scotia" (2022) in Annex B.
4. See Chris Davis, Cheryl McNeil, and Peter Gamble, "Communications Interoperability and the Alert Ready System" (2022) in Annex B.
5. The federal *Inquiries Act*, RSC 1985, c I-11, and the Nova Scotia *Public Inquiries Act*, RSNS 1989, c 372, empowered the Commission to summon witnesses, require them to give evidence orally or in writing, and "produce such documents as the commissioners deem requisite to the full examination of the matters into which they are appointed to examine."
6. *Inquiries Act*, RSC 1985, c I-11 at s 4; *Public Inquiries Act*, RSNS 1989, c 372 at s 4.
7. Ibid.
8. Hon. John W. Morden, Independent Civilian Review into Matters Relating to the G20 Summit, *Executive Summary and Recommendations* (June 2012) [Morden Report], 43.
9. National Inquiry into MMIWG, *Reclaiming Power and Place*, vol 1b, Annex A, 242.
10. For example, the Inquiry into Pediatric Forensic Pathology in Ontario used these "institutional reports" effectively. Ontario, The Inquiry into Pediatric Forensic Pathology in Ontario (Queen's Printer for Ontario, 2008) (The Hon. Stephen T. Goudge, Commissioner) [Goudge Inquiry], Report vol 4: *Inquiry Process*, 665.
11. Letter from Lori Ward, on behalf of the Attorney General of Canada, to Thomas Cromwell, "Re: Disclosure Issues" (June 24, 2022): COMM0059357.
12. Rules of Practice and Procedure (Appendix C) at s 19.
13. Independent Officer Review re: Susan Olive Butlin – Ernie "Junior" Duggan Complaints (RCMP, December 19, 2018): COMM0063223.
14. Independent Officer Review re: Police Involved Shooting – Peter DeGroot (RCMP, January 31, 2019): COMM0065374.
15. Summary Report re: Wellness Assessment (RCMP, September 30, 2021): COMM0062465.
16. Wigmore privilege is a case-by-case privilege that protects confidential communications. It applies if four elements are present in the particular circumstances of the document. These elements are, first, the communication must originate in a confidence; second, the confidence must be essential to the relationship in which the communication arises; third, the relationship must be one that should be "sedulously fostered" in the public good; and, fourth, the interests served by protecting the communications from disclosure outweigh the interest in getting at the truth and disposing correctly of the litigation. John Henry Wigmore, *Evidence in Trials at Common Law*, McNaughton revision, vol 8 (Boston: Little, Brown, 1961); *Slavutych v Baker et al*, [1976] 1 SCR 254; *R v Gruenke*, [1991] 3 SCR 263.
17. *Minister of Justice v Blank*, [2006] 2 SCR 319.

18. *Hudson Bay Mining and Smelting Co v Cummings*, 2006 MBCA 98.
19. *Fatality Inquiries Act*, SM 1989–90, c 30.
20. *Hudson Bay Mining and Smelting Co v Cummings*, 2006 MBCA 98 at paras 30–35.
21. Ibid at para 47.
22. Ibid at paras 61–109.
23. *Inquiries Act*, RSC 1985, c I-11 at s 4(b).
24. *R v Quesnelle*, [2014] 2 SCR 390.
25. *Sherman Estate v Donovan*, 2021 SCC 25.
26. *Youth Criminal Justice Act*, SC 2002, c 1.
27. The Ontario Provincial Police began an investigation of the leak, which was still underway when the Inquiry proceedings closed.
28. Decision regarding Enfield Big Stop Videos, June 20, 2022 (Appendix I-4).
29. Elliot Lake Commission of Inquiry, 460.
30. Foundational Documents were all tendered as exhibits and are listed in Appendix L; a sample Foundational Document is included in Annex A.
31. Nova Scotia, Premier's Office, "Statement on the Mass Casualty Inquiry," February 22, 2022, online: https://novascotia.ca/news/release/?id=20220222001.
32. We purposely avoided holding proceedings on these dates and tried to avoid holding proceedings on the 18th and 19th of every month. When the RCMP decided to hold the regimental memorial service for Cst. Heidi Stevenson on Wednesday, June 29, 2022, the Commission respectfully vacated public proceedings that had been scheduled for that date.
33. The mental health team developed a range of resources, including tip sheets, available on the Commission's website: https://masscasualtycommission.ca/support/resources/; samples are included in Annex A.
34. 211 Nova Scotia, online: https://ns.211.ca/.
35. Full text available in Annex A.
36. Rules of Practice and Procedure (Appendix C), s 46.
37. The complete Exhibit List is reproduced in Annex C.
38. A complete list of Witnesses, Introductory Panel Members, and Small Group Session Members can be found in Appendix N.
39. Decision with respect to proposed witnesses by Participants relating to the Portapique Foundational Documents, March 9, 2022 (Appendix I-1).
40. Rules of Practice and Procedure (Appendix C), s 43.
41. The decisions made about these submissions can be found at: Decision regarding Enfield Big Stop Videos, June 20, 2022 (Appendix I-4); Decision regarding Participant requests to question witnesses, June 17, 2022 (Appendix I-3); and Decision regarding Rule 43 accommodation requests, May 24, 2022 (Appendix I-2).
42. Goudge Inquiry, vol 4, 671.

43. British Columbia, *Forsaken: The Report of the Missing Women Commission of Inquiry, Executive Summary* (British Columbia, 2012) (The Hon. Wally T. Oppal, Commissioner), vol. 1, 13.
44. Newfoundland and Labrador, Public Inquiry Respecting Ground Search and Rescue for Lost and Missing Persons in Newfoundland, Final Report (Queen's Printer for Newfoundland and Labrador, 2021) (James Igloliorte, Commissioner), 77.
45. Australia, Royal Commission into Institutional Responses to Child Sexual Abuse in Australia, Final Report, vol. 1: *Our Inquiry* (Commonwealth of Australia, 2017), 24.
46. *Police Identity Management Act*, SNS 2021, c 8.
47. See Grete Dyb, Kristin Alve Glad, Ingebjørg Lingaas, and Synne Øien Stensland, "Survivors and the Aftermath of the Terrorist Attack on Utøya Island, Norway" (2022) in Annex B.
48. See Bjørn Ivar Kruke, "Police and First-Responder Decision-Making During Mass Casualty Events" (2022) in Annex B.
49. See Bethan Loftus, "Police Culture: Origins, Features and Reform" (2022) in Annex B.
50. Laurence Alison and Neil Shortland, "Critical Incident Decision Making: Challenges of Managing Unique and High-Consequence Events" (2022), 1, in Annex B.
51. See Chris Davis, Cheryl McNeil, and Peter Gamble, "Communications Interoperability and the Alert Ready System" (2022) in Annex B.
52. See Curt Taylor Griffiths, "Interagency Communications, Collaboration, and Interoperability Within Police Services and Between Police Services and Other Emergency Services (2022) in Annex B.
53. See Holly Campeau, "Culture in Police Organizations: Definitions, Research and Challenges" (2022) in Annex B.
54. See Chris Murphy and Cal Corley, "Community-Engaged Rural Policing: The Case for Reform and Innovation in Rural RCMP Policing" (2022) in Annex B.
55. See Benjamin Goold, "Exercising Judgment: Understanding Police Discretion in Canada" (2022) in Annex B.
56. See Anna Souhami, "A Systematic Review of the Research on Rural Policing" (2022) in Annex B.
57. See Karen Foster, "Crime Prevention and Community Safety in Rural Communities" (2022) in Annex B.
58. See R. Blake Brown, "The History of Gun Control in Canada" (2022) in Annex B.
59. See Joel Negin, Philip Alpers, and Rebecca Peters, "Firearm Regulation in Australia: Insights from International Experience and Research" (2022) in Annex B.
60. See Jaclyn Schildkraut, "Supporting Survivors and Communities After Mass Shootings" (2022) in Annex B.
61. See Tristan Bridges and Tara Leigh Tober, "Mass Shootings and Masculinity" (2022) in Annex B.
62. See David C. Hofmann, Lorne L. Dawson, and Willa Greythorn, "Core Definitions of Canadian Mass Casualty Events and Research on the Background Characteristics and Behaviours of Lone-Actor Public Mass Murderers" (2022) in Annex B.

63. See Carmen Gill and Mary Aspinall, "Understanding Violence in Relationships" (2022) in Annex B.
64. See Kristy Martire and Tess M.S. Neal, "Rigorous Forensic Psychological Assessment Practices (Part I and II)" (2022) in Annex B.
65. See Katreena Scott, "When We Know Something Is Wrong: Secondary and Tertiary Intervention to Address Abuse Perpetration" (2022) in Annex B.
66. See Brian Braganza and Nick Cardone, "Conceptions of Masculinity and Violence Towards a Healthier Evolution of Men and Boys" (2022) in Annex B.
67. See Gayle MacDonald and Meredith Ralston, "Health and Safety of Survival Sex Workers in Halifax and Truro, Nova Scotia" (2022) in Annex B.
68. Mass Casualty Commission, Transcript of Public Proceedings (August 29, 2022), online: https://masscasualtycommission.ca/files/documents/transcripts/EN_20220829_PublicHearings_Transcript.pdf?t=1673441558.
69. Nova Scotia, Royal Commission on the Donald Marshall, Jr., Prosecution, Digest of Findings and Recommendations 1989, vol 7: *Consultative Conference November 24–26, 1988 Edited Transcript of Proceedings*, Nova Scotia Archives (Chief Justice T. Alexander Hickman, Chairman), online: https://archives.novascotia.ca/marshall/report/#vol7.
70. Full text included in Annex A.
71. At the time of closing remarks, only 22 commissioned reports had been tendered as exhibits. The final commissioned report was tendered during virtual proceedings on October 27, 2022.

CHAPTER 6

Expenditures

1. Nova Scotia, Desmond Fatality Inquiry (2018), online: https://desmondinquiry.ca/index.html.
2. Nova Scotia, Westray Mine Public Inquiry, *The Westray Story: A Predictable Path to Disaster* (Justice K. Peter Richard, Commissioner) (Province of Nova Scotia, 1997), online: https://novascotia.ca/lae/pubs/westray/.
3. Canada, Commission of Inquiry into the Sponsorship Program and Advertising Activities, *Restoring Accountability – Recommendations* (Ottawa: Privy Council Office, 2005) (John Gomery, commissioner), online: https://publications.gc.ca/site/eng/9.688112/publication.html.
4. John C. Major, *Air India Flight 182: A Canadian Tragedy* (Government of Canada, 2010), online: https://publications.gc.ca/collections/collection_2010/bcp-pco/CP32-89-4-2010-eng.pdf.
5. *Financial Administration Act*, RSC 1985, c F-11.