MASS CASUALTY COMMISSION
COMMISSION DES PERTES MASSIVES

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

Commission fédérale-provinciale sur les événements d'avril 2020 en Nouvelle-Écosse
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Public Hearing

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Commissioners / Commissaires

The Honourable / L'honorable J. Michael MacDonald,
Chair / Président

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

Dr. Kim Stanton

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Dr. Emma Cunliffe	Director of Research and Policy / Directrice des politiques et recherches

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Halifax, Nova Scotia

--- Upon commencing on Tuesday, June 28th, 2022, at 9:34 a.m.

COMMISSIONER FITCH: Bonjour et bienvenue. Hello and welcome. We join you from Mi'kma'ki, the ancestral and unceded territory of the Mi'kmaq.

Please join us in remembering those whose lives were taken, those who were harmed, their families, and all those affected by the April 2020 mass casualty in Nova Scotia.

Thank you to everyone for joining us, both those here in person and the thousands that we know are watching online as well. This week, we are building on everything we have learned so far by continuing to explore the how and why the mass casualty happened. Our mandate requires us to examine a number of related issues.

Last week, we looked at post-event communications and supports, and how different police services collaborate with each other. The Foundational Documents, supporting materials and webcasts of proceedings from last week are available on our website.

This week, we will continue to focus on post-event supports as well as police actions, policies and procedures, with a particular focus on how these work in rural communities. Today, we'll be hearing a roundtable discussion regarding the needs of families and communities after mass casualties. Roundtables like this continue to be an important way for us to hear from experts and others with relevant experience so we can develop and share well-informed recommendations and lessons learned going forward. After the roundtable, Commission Counsel will be marking a number of documents as exhibits before we conclude today's proceedings around 1:00 p.m.

I will now ask Dr. Emma Cunliffe, Director of the Commission's Research and Policy team, to introduce the roundtable members and facilitate today's discussion. Thank you.

Dr. Cunliffe?

DR. EMMA CUNLIFFE: Thank you, Commissioners.

--- ROUNDTABLE: NEEDS OF FAMILY AND COMMUNITY AFTER MASS CASUALTY INCIDENTS:

DR. EMMA CUNLIFFE: Good morning. As Commissioner Fitch has indicated, my name is Emma Cunliffe, and I have the honour of serving as Director of Research and Policy for the Mass Casualty Commission.

Much of the work that forms the basis for today's roundtable discussion has been led by a member of the Research and Policy team, Nichole Elizabeth, who has completed many interviews with community members and service providers, and conducted extensive research to identify best practices and interesting models for community and family support.

As facilitator of today's roundtable, I will be discussing the questions, asking follow up, and moderating dialogue. I would ask those of you who are participating in this roundtable please to speak slowly for the benefit of our accessibility partners.

Roundtable discussions form part of the Commission record. They are being livestreamed now, and will be publicly available on the Commission's website. The Commissioners may choose to pose questions or ask for clarification at any point.

The Commission has heard evidence and amassed information about the impact of the mass casualty of 18 and 19 April 2020, on those families who were most affected, and on the aftermath of the mass casualty. We have sought this information by many means, including through meetings with family Participants; interviews with community members and service providers, which have and will be tendered before the Commissioners; and documents generated by those agencies who were tasked with supporting and providing information to families and communities, including the Nova Scotia Government and the RCMP.

The Commission has produced Foundational Documents that summarise much of this evidence, and we anticipate that more documentary evidence

will be tendered next week. The Commission has also conducted a "share your experience" consultation through which many community members shared with us the deep and lasting ways in which the mass casualty has impacted them and their communities. We have spent time in the affected communities, including through a series of open houses and when conducting interviews and investigations.

This is also a good opportunity to remind you that we are presenting conducting a further consultation, this one online, in which we are seeking input about the recommendations that you would like to see considered as part of the Commission's work. You can find more information about this consultation on the Mass Casualty Commission website at masscasualtycommission.ca. Under the Proceedings menu, look for the option called Public Submissions.

The commissioned reports produced by Dr. Grete Dyb and her colleagues at the Norwegian Centre for Violence and Traumatic Stress Studies, and by Dr. Jaclyn Schildkraut, document on the basis of empirical research that experiencing a mass casualty has deep and far-reaching impacts on survivors, families and communities.

We're fortunate to be joined today by these report authors, and also by other experts, who bring deep understanding of the support needs and experiences of individuals, families and communities to the table. In a moment, I'll invite these experts to introduce themselves to you and share -- and to share a little more information about themselves and their experience with the matters we'll be discussing today.

As with all of the Commission's roundtables, today we will not focus specifically on the mass casualty of April 18 and 19, 2020, nor will we seek to interpret the evidence that's before the Commissioners about how service providers, communities and families experienced and responded to the mass casualty. That work is being done in other aspects of the Commission's process.

Today, we will focus on the insights and best practices that can be

found by looking to other communities who have experienced mass casualties, and our roundtable participants will share both their expertise and their experience with these matters.

The core themes for this roundtable are, first, the immediate, short-term, and long-term needs of those impacted by a mass casualty, with particular attention to the needs of the families of victims and members of communities closely connected to a mass casualty; second, best practices for addressing these needs; and third, models that support grief, promote healing, and foster resiliency.

Our intention is to provide a deeper understanding of the core themes so that everyone is well-positioned to engage in conversations in Phase 3 about the lessons learned about what constitutes effective approaches to supporting survivors, families and communities, and to contribute to potential recommendations on these matters.

To get us started, I am going to ask each of our roundtable members to introduce themselves, and I will begin with those who are joining us virtually today.

If I may please begin in Norway. Please go ahead and introduce yourself.

DR. GRETE DYB: Yes, hello. My name is Grete Dyb. I'm a professor in child and adolescent psychiatry at the University of Oslo, and I had a research at the Norwegian Centre of Violence and Traumatic Stress Studies, where I have conducted a study on the survivors of the Utøya shooting attack, where we lost 69 youths in 2011. They were participants in the summer camp, and the shooter came to the island and shot as many as he could before the police came. And we followed them up over a period of almost nine years in four data waves, and that's what we have shared with you in our report.

DR. EMMA CUNLIFFE: Thank you very much indeed, Dr. Dyb, and thank you for joining us today.

If I may now turn to Levent Altan.

MR. LEVENT ALTAN: Good morning. My name's Levent Altan. I'm the Executive Director of Victim Support Europe. Maybe just before I start, I'll say thank you also for the invitation to speak here. I think it's an honour, and certainly all of us in this sector think it's extremely important to have these inquiries and to make sure that victims' voices are heard, so thank you for that invitation.

I've been working the last 20 years in the criminal justice counterterrorism field. I've worked in the UK Civil Service, but in terms of victims, I worked in the European Commission to develop victims legislation before moving over to Victim Support Europe, where I've been the Director for the last eight years.

Just quickly, Victim Support Europe is a -- we're an umbrella organisation of 70 members in 34 countries. Those organizations support all victims of crime and supporting somewhere in the region of two and a half million victims per year.

What we've been doing over the last, I would say, seven or eight years, is having also a specific focus on victims of terrorism coming out of the Paris attacks where we assisted the national response framework with respect to foreign victims, and in the following years, supporting the European Commission, supporting the United Nations with the development of policy frameworks, but also running a youth center of expertise for victims of terrorism, as well as working with national governments, such as the Belgium Government to look into how they could improve their responses after the Brussels attacks in 2016.

Thank you.

DR. EMMA CUNLIFFE: Levent, thank you for joining us today.

Mary Fetchet, if I may turn to you, please?

MS. MARY FETCHET: Good morning. My name is Mary Fetchet and I want to start by offering my condolences to the families that lost loved ones, and of course all of the community, those that survived and those that are now tasked with responding and providing support.

I'm a social worker and I've worked in the field for over 29 years. In 9/11 we lost our son Brad. He was -- well, we didn't lose him. He died in the attacks on September 11th. He was working in New York City and he was one of 2,977 that died.

So my response to his death was to start an organization that was formerly called Voices of September 11th, but because we're doing so much work beyond working with 9/11 families, who we continue to provide support for, we're also working with other communities to make sure that we can share our lessons learned to help communities respond to the tragedy.

So we provide long-term support for the victims' families. They lived in 93 countries. What we're seeing right now, of course, is that medical and mental health challenges that the survivors and responders are experiencing because of their exposure to toxins in the aftermath of 9/11

We started doing research about 10 years ago and so we've developed best practices in providing the immediate, short term, and long-term needs.

We also have done a lot of public policy work. I was one of 12 family members that pushed for the 9/11 Commission to be established, and that led to sweeping intelligence reforms.

And we also worked very closely with Memorial, even before they had a structure in place to make sure that the victims' families and the stories of survivors and responders are told. And we collected over 87,000 photographs of the victims and shared that collection with Memorial when they had built it.

And then we've also done a lot of public policy work, working with some of the organizations that have responded, like the Medical Examiner, who still today is identifying remains of our loved ones.

So I think that, you know, as I started, our condolences to all of the families and I'm sure that everyone that's speaking today joins in our offer to help with support that's needed to make sure that you have the capability to move forward and heal.

DR. EMMA CUNLIFFE: Thank you very much, Mary. We're very glad to have you with us today.

Megan McElheran, please go ahead.

MS. MEGAN McELHERAN: Good morning. Thank you, Mary, for sharing condolences on our behalf. I echo that sentiment.

My name is Megan McElheran and I'll just note that I'm joining today from Treaty 7 lands in Calgary, Alberta, home of the Blackfoot Confederacy, which includes the Tsuut'ina, the Nakoda, and the Métis Nation of Region 3.

I'm tremendously honoured and humbled to be part of today's proceedings and thank you for the invitation to join.

I'm a practicing clinical psychologist in Calgary and the head of a community-based mental health practice where the work that we do is with individuals in the community, organizations, families who have experienced traumatic events and who may have gone on to experience mental health difficulties as a direct result of those traumatic events.

So I spend much of my time sitting with people, helping them to work through the losses and the traumas that they have suffered.

I'm additionally focused on research in the area of post-traumatic growth. So specifically the idea that how and in what ways we help people recover from the adversities and the tragedies that they face can have an impact in terms of their overall growth and development.

I also spent time involved in research projects looking at resiliency, and so bring that lens to this conversation as well, how and in what ways do people feel a sense of resiliency and capacity within themselves enhanced as they go through, again, tremendous losses and suffering.

So I am particularly here today with the, you know, the recent and ongoing experience of working with folks who've experienced trauma, and I'm hoping to bring some degree of insight into what we know can help people in this type of recovery

and healing process.

So thank you very much again for having me here.

DR. EMMA CUNLIFFE: Megan, thank you so much for joining us. We're really looking forward to the conversation today.

If I may now turn to those members who have joined us in person today?

Serena Lewis, sitting to my left, please go ahead.

MS. SERENA LEWIS: Thank you, Emma.

My name is Serena Lewis. I would like to start my introduction first by acknowledging that I am a mother, I am a daughter, I am a sister, I am a friend, and I am a neighbour to a very weary, weary community.

I live in Great Village and the impacts of this have been profound on myself, my family, my friends. I offer condolences to all of the people in the room who have come here to support me, and I hope subsequently that we can help support the families and the families and the entire community that, again, has been brought to its knees over this.

I am a constituent who votes at a municipal, provincial, and federal level. I vote every time I have an election.

I am a professional working with a master's degree. I have spent 20 years specializing in the fields of death, dying, and grief. I have had the privilege of working with my local communities, my provincial communities. I have spoken at both national and international conferences.

I acknowledge that I am sitting here on the unceded territory of the First Nations communities of the Mi'kmaq. I think it's incredibly important that we recognize truth and reconciliation, that the foundation of this is really pully apart the understanding of grief and trauma that our country, our province needs to address through this truth and reconciliation process that we're on.

I acknowledge 400 years of colonization and impacts on the

oppression of our Black and African-Nova Scotian communities. Again, acknowledging grief and trauma.

Our Acadian population here in Nova Scotia, part of our history and the land that we sit on.

I acknowledge that throughout covid, for the past two years, the complexities of grief and trauma in this country and in this province escalate and tragedies that we haven't even begun to be able to talk about yet.

I acknowledge that we're a province who is welcoming newcomers graciously, but also recognizing they too are bringing their grief and trauma from war-torn countries.

I acknowledge all of my fellow panel members, who again have acknowledged that this part of the subject material that they're working with also are the many, many lives that have been lost through mass casualty events.

I acknowledge the impact of grief and trauma from a gender-based violence lens that's very much intertwined in all of this that we're here to talk about today.

But importantly, today, this mass casualty event has had profound -- profound -- impacts on the people that I love, the people that I care about, and the colleagues who are working incredibly hard across our province to keep people supported throughout this. So I thank you for being part of this, from my professional stance. I also deeply acknowledge my personal experience with this as well.

DR. EMMA CUNLIFFE: Serena, thank you so much for joining us today. And in turn, I'd like to acknowledge the courage and the generosity that you're showing in joining us.

Terry Mitchell?

DR. TERRY MITCHELL: Hello everyone, hello Commissioners and our panel. My name is Terry Mitchell. I am a community psychologist and a registered clinical psychologist. I've been working for my entire professional life in the

area of trauma, and I'm here today with respect and humility for what I might offer, based on my limited experience in Nova Scotia. I now live in Prince Edward Island. I am a recently retired professor who was at Dalhousie and have recently returned. I was away for a long time, and I've recently retired and returned to the Maritimes.

I was once at Dalhousie. I began in working in community health and epidemiology and at Dalhousie in the Faculty of Medicine in July 1998. On September 2nd, you will recall that this was their disaster, response efforts of your communities begin. And that's when I was invited, as a new faculty member, they were, like, "You're a community psychologist. Maybe you could address this." I built together an interdisciplinary team of faculty members, but most importantly, over a number of years, I brought together a community advisory group, emergency measures, fishers, fire chiefs, social workers, religious leaders and civic leaders. And with working with them, they guided me on what questions we should ask and how to go forward. So with great humility, I'm here to share whatever lessons we may bring from those early experiences.

DR. EMMA CUNLIFFE: Thank you so much for joining us today, Terry.

And Jaclyn Schildkraut.

DR. JACLYN SCHILDKRAUT: Thank you all for having me, Commissioners, and, Emma, for bringing me here, and to the communities that are represented here for having me as well. I echo my fellow panelists in offering my condolences to all who were affected in any capacity.

I am an associate professor of criminal justice at the State University of New York at Oswego. For the last 15 years, I have studied various aspects of mass shootings in our country. And from 2014 to today, I have worked with survivors who have been impacted by these tragedies professionally. In 2017, after conversations with many of these individuals about what their recovery and resiliency process looked like, what the aftermath of these events meant to them and to their

communities, I started conducting research to in part give survivors a voice that often was left out of the conversation in our nation. And through that, I've learned many things that I hope me being here today will allow me to serve as a vehicle to help share those stories and those lessons. I take no credit for them, just simply for being able to share them on their behalf.

I also parch this personally, as I come from two communities that have had very -- have had mass casualty events. I grew up in the Parkland, Florida area where on February 14th of 2018, a member of our community entered a high school and took 17 members of our community away from us, injured 17 others, and changed a place I've known my entire life in a matter of 6 minutes. I also went to college in Orlando, Florida, which is where the Pulse Nightclub shooting occurred in 2016, where we also lost 49 members of our community, had 53 others injured, and again, another community that I love and hold so dearly impacted. So I come before you today humble and grateful to be a part of this opportunity to help and to provide support in a way that I feel is often needed and maybe we don't necessarily know how to do. So, thank you for allowing me to be part of this.

DR. EMMA CUNLIFFE: Jaclyn, thank you for joining us.

Let's begin our conversation today, as many of our roundtable members have already done, by discussing relationships and recognizing the context in which we're here to have today's conversation. You've already heard that some of our roundtable members have direct, personal experience of the grief and trauma of losing loved ones or community members in a mass casualty incident, while others have spent years working in community and with individuals who have suffered this grief and trauma. Some of our roundtable members have asked that we start with an opportunity to address those survivors, family and community members who are here in person today or who might be following along with the webcast because they lost loved ones in the mass casualty.

Mary, you've spent more than 20 years as an advocate for long-

term supports for those affected by mass casualties and an advocate for government reform. As a mother who lives with the grief and trauma of the death of your son Brad in the 9/11 terrorist attacks, is there anything more that you would like to say to those whose family and friends died in the Nova Scotia mass casualty?

MS. MARY FETCHET: Well, again, I just go back to offering, you know, my condolences. Any time there's a tragedy like this, you know, it brings us back. I think I can speak on behalf of any victim, you know, being exposed to the news and understanding the long journey they have, and with the hopes that they have the support that they need. I think it's so critical, you know, what you're doing today, to pull people together that can help guide you along that long journey, but hopefully too, I think that those of us that have gone through it, and maybe it's a different type of tragedy, but the loss and the grief is the same, and that's something that we have to deal with.

I think the thing that I heard that was most insightful early on is to recognize that everybody goes through grief differently, and they go through it in their own time, and that you have to recognize not just for yourself, but recognize for your family and friends that, you know, you go through it differently. And I think there's challenges with that. But if you take that into consideration and accept that, and to try to understand where -- who are the both -- best people to provide that support that you need, because the support is very different based on how you're going through it. So I just go back to, I think, having -- you know, pulling this event together today, to be able to give us some insight into, you know, that journey and hearing from people that have either experienced or worked with people that have, is a really good first step.

DR. EMMA CUNLIFFE: Thank you.

Serena, you live and work in the communities that were most affected by the mass casualty. What would you like to say to your neighbours and friends who are listening to today's roundtable about the work that we will do here today?

MS. SERENA LEWIS: Thank you. I think it's really important today to acknowledge while we're looking at the research to help inform the process to make recommendations that we're also living this experience in very real time, and time is an interesting factor when it comes to grief and trauma. As we've just heard you indicate, Mary, as you remember and share your story about your son as well, I think it's deeply important that we're remembering that our province is raw right now. People sitting here in the room today, those watching, that we're all living this experience. Whether we were somebody who responded on the events of April 18th and 19th, whether we are family members, whether we are community members now in our schools, our long-term care facilities, our hospitals and our markets, I think we've all been touched by this. So as we navigate this space today, and we delve into the research and understand how this unfolds for people, I think it's very important that we have not forgotten that this is not research matter. These are people's lives. These have been people's deaths and this is all of our grief and trauma experience, and we don't want to lose sight of any of that today as we work this process through to be able to talk about where are we going to go with this.

DR. EMMA CUNLIFFE: Thank you.

Terry, you spent two years developing the community relationships in the Peggy's Cove area that allowed you to do your ground-breaking study of the impacts of the Swiss Air disaster on the community. In our conversations preparing for today's roundtable, you had emphasised that the work of understanding these harms and supporting communities should begin and proceed in relationships. What does this mean to you?

DR. TERRY MITCHELL: It means everything. And especially for those who have been most effected, relationship means everything. It's relationships they've lost, relationships that sometimes are broken through the stress and the conflict that arises after loss and during grieving, in times of trauma.

But in terms of being a researcher, an ally, a colleague, a

neighbour, a friend, the relationship is important that it be based on trust and that it be based on humility, and it be based on an understanding of the profound ignorance, not of our own fault, but as an outsider, I don't have the knowledge required in order to do necessarily what is needed in the best way.

And I draw -- I wish to say that you may hear in my language that I draw a lot from my experience of working with Indigenous peoples over many years, who, as Serena mentioned, are still subject to colonialism and the trauma and losses and the colonial trauma that continues. But in that, I learned that relationship is everything, and relationship does not -- is not meaningful or important or effective unless it's based on both respect and humility.

So beginning and taking time. Relationships don't just happen because, "Oh, I have a research grant, or there's a research problem, or there's a disaster and a response is needed", relationships develop over time. And what was important, as being an outsider, in many, many -- in many, many ways, I was very new to Nova Scotia at the time, but is that I needed to find out who could tell me where to begin, how to begin, not just to find some people who could represent for a research program, but who could represent for the community. Who had the respect already? Who had the trust already amongst one another? So beginning to find community informants that were respected and trusted by their community and having them guide me, then, who else should I talk to? Who else should I speak with?

And -- and so meeting in the firehall, meeting in the church basements, meeting in people's homes over tea, and then -- moment by moment, then fishers are telling me, "You've got to go talk to so and so", and the fire chief's saying, "Well, you have to -- well, you can't do this without so and so." So it began like that. And so then they began to develop relationships with me and trust with me, and then it continued. So it means everything.

And I want to acknowledge in case I, in my long-winded way, forget at some other point to say that what's important in all of that is to identify that the

knowledge is in the community. The relationships, why are they important, because the knowledge is there, the capacity is there, the sense of priorities are there, and the capacity is there in terms of people.

So I want to acknowledge Serena Lewis as a community champion. So in research and in interventions of any kind, a first step is to identify and develop and support, if they're -- if they don't identify themselves, to support community champions and to help them to lead the way. So it means everything.

DR. EMMA CUNLIFFE: Thank you very much.

Meghan, you're a community psychologist who works closely with communities that have experienced trauma. How would you begin today's conversation? What information or insights would you like to share about working with those communities?

DR. MEGAN McELHERAN: Yeah. I -- I'm just appreciating what everyone has said so far. I have a couple of thoughts or a couple of offerings that I'd like to add in just for consideration.

You know, as I sit here and I think about the events that have been experienced and what this has been like over the last couple of years, with the unbelievable complication and experience of COVID layered on top of this, and all that has meant for ways in which connection has been that much more difficult, my heart breaks, honestly. I am just -- I am so sorry that this -- that this tragedy and casualty occurred.

And one of the things I reflect on that I think is so important for communities and for families and for people who have lost loved ones to understand, and yet it's one of the hardest things to confront, is that there is no going back. That there is something that has happened here, and things will -- I mean, grief by it's very nature means we will never have again what we once had. And due to the events that happened in April 2020, there is now what I like to think of as almost like a fault line in the earth, and there can be rebuilding, there can be growth, there can be change, any

number of things, but part of the grief we have to help people acknowledge and work through is that there will now be a moving forward, not a return to how things once were.

And I think what's important in that is that we respect that, as Mary said, grief happens and people experience grief in different ways and at different times, I think it's important to know or acknowledge that in this kind of an experience there are multiple different kinds of grief. So there is, you know, perhaps the direct grief of losing a loved one, there is also the grief that is -- that is part of being in a community where this occurred and what this now means for a community to have to find ways to recover together. And that I underscore, the coming together and the finding ways to truly build bonds off of trust and a deep desire to seek to understand the experience of community is essential. But we have to understand that there is all of these different layers and types and experiences and ways that grief shows up that is going to be very different at different moments in time, that is going to be very different from person to person.

You know, I often reflect on, you know, as someone who works with those who have gone through trauma and who are trying to reclaim their lives, you know, the world of the psyche and the soul and the heart doesn't keep time the way that the physical world does. In many respects, in the world of the psyche there is no time, and so we need to, you know, allow community members and family members to not put pressure on themselves because a certain amount of time has passed or certain things have unfolded. In fact, you know, grief is increasingly a process of learning to live with what has been lost and learning to live with what has changed, and finding ways to, you know, continue to honour and grow and make meaning out of experience, but that cannot happen on a timeline.

And you know, as -- you know, I would still -- I would hasten to submit or I would humbly submit that the community is very, very still in the early days of this, and I think particularly because of the complications that COVID has brought to the community, it is going to be -- there is going to be a great likelihood that there is a

sense of, you know, there is too much pain to bear and it's hard to share yet. And the recommendation often and always, from my perspective, is finding ways to stitch together those bonds of connection with other people who can, you know, to some extent understand what the lived experience is of all of these nuances and all of these vagaries of grief that everyone is experiencing.

DR. EMMA CUNLIFFE: Thank you.

Grete, thank you for joining us today, especially as you and your community begin the difficult work of assisting your fellow Norwegians, who have experienced another mass casualty just this past weekend. Please carry our condolences and our best wishes back to your fellow Norwegians as you do this work.

Based on your very extensive experiences studying the trauma, somatic impacts and lasting impacts of a mass casualty or a terrorist incident on a large population of Norwegians, what would you say today to the families and communities who have suffered harm in Nova Scotia, and to those who might seek to support these families and communities.

DR. GRETE DYB: Thank you, Emma. I'm so grateful to be here and I sincerely hope that you can use some of our experiences to help your own community.

I apologize for not having the detailed knowledge of the local community that you all have, but I will echo what you said, Megan, about you're definitely in an early stage, because what we have documented is that these processes are slow, they fluctuate over time when it comes to symptoms and hardships, and there are needs in a long period of time after such a mass casualty event.

So that's the knowledge that we have.

And I think that what motivated us to do this longitudinal study and this amazingly very hard work that the group has done to get together all this data was that we realized that we had very little knowledge when we were asked from the government to give them advice on what our survivors, their families, and the bereaved

families actually needed after the terror attack.

We looked at mass shootings in the U.S. There have been so many. There are so few longitudinal studies that have actually followed up.

So our work has actually been to try to overcome some of these difficulties in research. And our study, we have recruited eight out of 10 to participate in the study at at least one time point. So the difficulty is with having very few recruited and we don't really -- cannot really generalize our findings. I think we overcame that and can say that our study results can really tell what most of the survivors were feeling, and difficulties they had.

Also that long-term documentation is so scarce. I mean, only a few studies have followed survivors over time. And that really gives us no answers because if you start studying and you go on for two years, it looks very nice because you get a very nice recovery slope and you think that, oh, this is going really well. But what we saw was that for PTSD, depression, and anxiety, we had this nice slope the first year, and then it flattened out. And actually, on our fourth data wave, almost 10 years after, it increased a little bit, significantly, statistically significantly. And that shows us that some of these symptoms of PTSD, together with the grief that they have, is really a long-term difficulty for them.

And we also saw that they had a lot of symptomatic symptoms, like pain and headaches. They had bad sleep. That affects their concentration and it impacted their education.

We have linked to registry data where we can see their marks in school. I don't know if you have that in Canada, but we do have that in Norway. And we see that they are left behind here. They have struggled in school and they have struggled in their education and going on with having work, a career. So it has long-term impact also in that perspective.

And we are not only concerned about the survivors. We have interviewed them personally with health personnel four times because we knew that

they were in crisis, so we wanted to make sure that they were taken care of during the interviews, and it's heartbreaking. It is heartbreaking to see how young people suffer over such a long period of time, but also their family and their siblings, and siblings in those families that are bereaved and lost someone. So it's a -- it's a big -- you know, it's not only one person. It's their network and their close ones. Many of the parents, they got a youth back home who was so changed and had so many difficulties over time and needed help.

And we had an outreach program that was actually very well funded on evidence that we had at the time with a proactive outreach from the municipality to all the families over time for a year. But after less than a year, most of the municipalities had given up. So specialized mental health services helped a lot. Sixty-nine/seventy (69/70) percent of the survivors needed help from mental health services, and over time, they had help from them.

But even that didn't really take away all the symptoms, as you see, that four to five months after the terror attack, five in 10 were at the clinical level of PTSD, and almost 10 years after, still three out of 10 were in that level. So Megan said, like, clinical level and full PTSD or above what we consider at the clinical level so that they need professional help.

And unfortunately, I don't think this -- that our studies are a special study. I think that we would have found this if we did studies after all these events. And I think that documentation like this is important to make governments and local authorities to realize that it's not only the acute help in the months and a year after that is important. That is very important, but it also has to last over time and we cannot leave all these people behind because we think that recovery and resiliency is just so powerful that they can manage on their own. These symptoms are hard to treat sometimes, and also people, they meet other difficulties in their life. They meet other challenges. And typically that stress that they meet in other situations, that would also impact how they feel about their trauma.

So, yeah, I hope that was a little answer to your question, Emma.

DR. EMMA CUNLIFFE: It was indeed, Grete. Thank you.

So throughout today's conversation, we'll be using language and drawing on concepts that are technical or maybe unfamiliar to some. For that reason, I'd like to turn now to a brief discussion of some of the key concepts will be discussing and why they matter.

Levent, if I can begin with a fundamental question for you? When a mass casualty happens, many people are affected by that incident. What does your office have to say about how governments and communities should understand the reach of these impacts? Whom should we include within our contemplation of those who have experienced grief and trauma, and how should we take their needs into account?

MR. LEVENT ALTAN: Those are very good questions. So I think let's start off with the question of who is affected, really?

So traditionally we tend to talk about victims or survivors in quite a technical and legalistic sense, which leads us down quite a narrow definition of who a victim is and maybe, for example, we define a victim of crime as someone who has suffered harm as a consequence of a crime.

But when we're thinking about how we have to respond and prepare for any kind of mass casualty event, we have to think in a much wider turn, really.

And part of what we try to get across to governments is if you want to effectively respond to terrorism or other kinds of deliberate mass casualty events, if you want to respond effectively and minimize the objectives behind that kind of attack, then you need to properly address all of the harms that it causes, and then -- therefore you need to understand all of the different individuals and communities that are affected.

And your definition may change depending on the purpose, but the

starting point is to know everyone that's affected. And we look at this from a sort of concentric circle, as we call them, circles of impact, and we start off with those really who were present at the scene, may have been physically or psychologically impacted in some kind of way. The technical term to refer to it is direct victims. And that's already quite difficult, to determine who might be that kind of a direct victim. It's not an easy task.

For example, after the Nice attacks over in France, that you had a truck that drove through very crowded streets just by Nice Beach, and it -- and there, there were many people who were very close to the scene or to the path, and the governments had to try to work out who might be those direct victims. The reason you need to do that, by the way, is because you do have to understand who may have legal rights within criminal proceedings, who may be benefitting, or, for example, compensation from the state or from the offender. So you have to have some kind of, well, good understanding who -- of who those victims may be.

Then you have these concentric circles moving outwards, those who may have seen or been near to the attack, those who responded, first responders, professional or civilian. Many of the people who are first on the scene were not personally impacted in a physical way, but they would have gone directly to the scene to help those who have been injured. They will be affected in all sorts of ways. There will be -- moving out from that, the first responders as I say, but also, you've got the family and friends, and then you have wider communities, and that may be shop owners. It may be the schools where -- from where the children came from. It's -- you can never predict, let's put it this way, you can never predict which of the communities and individuals are affected. What you have to understand is that you're looking for those impacts, and understanding how those impacts happen, and going as wide as possible. That's the starting point. And the purpose behind that is to them determine what is the kind of response or assistance that you need to provide and the framework that you need to provide to address that. So that's the fundamental parts, starting points.

You try to work out what you need to do to address those. It's about really understanding impacts, understanding the needs of victims, and understanding the barriers that victims face to having those needs addressed. The impacts, I won't go into all the impacts, but there's psychological, financial, emotional, practical. There are many different types of impacts we could go into.

When it comes to the needs, we can summarise those needs in terms of, first of all, the need for respectful treatment and recognition. And the recognition elements, particularly in mass casualty situations is important, both in the immediate term, even, for example, with a terrorist attack, recognizing an attack as terrorism is a form of recognition, but it may also result in additional rights and services for people who are affected. So recognition in many different forms within the mass casualty situation. Memorials is a very important aspect of recognition.

Respectful treatment, which is both the way that the victims are treated in terms of the human interactions, but also in terms of the way that the structures and procedures are set up to be respectful towards victims. So, for example, in the -- after the Brussels attacks, the state compensation system is also aligned with the insurance system, and victims were receiving template letters from insurance companies, in which they asked if they knew -- they were asked if they knew the perpetrator, and there was a very strong reaction, understandably, from people that you can't just send out a template letter for this kind of situation. So respect and recognition is extremely important.

Protection from further harm, but also protection from secondary victimization, which is the negative impacts that victims experience as a consequence of the way individuals and societies respond to them. And that may be the way that we talk to them. It may again be those procedures, but we can harm individuals in lots of different ways, and our procedures and our behaviours have to be designed to not cause further harm.

Victims need support; all different kinds of support. They need

justice, access to justice, which includes being heard and participating in that process. And they need compensation and restoration, which, you know, is the financial and non-financial aspects. So you can summarize all of those needs in those terms. Obviously, it becomes more complex in terms of understanding how precisely you do that. What's important to also know is that those needs and the responses differ according to different groups. So you may come from a specific community, you may have gender-specific needs, you may have racial-specific needs, religious-specific needs, for example, which need to be taken into account. So you have this group characteristics which may adjust your needs, but also require you to adjust your responses. And then each individual will have their own needs based on their own personal characteristics, their history, some of those points that Grete was making about the way that grief changes or is affected by different aspects of the person's life.

So what that means is, our responses have to be comprehensive, and there's a lot that we can do which is able to address all the -- all victims and all those harmed, but it has to be individualized and flexible to be able to address the specific needs of each individual.

When we talk about victims of mass casualty or victims of terrorism, we lump everyone into this big label, and every single person is different because of their entire situation, but we have to have systems in place which are able to flex according to those situations and adapt to them. And that sounds like an impossible task, but it is being done. There are good practices, those who are able to address it. So I think that's a very short answer to begin with.

DR. EMMA CUNLIFFE: Thank you.

Jaclyn, we've heard from Levent that a very wide range of people can be affected by a mass casualty incident. In your commissioned report, which for the benefit of the record, is Exhibit P-002619, you allude to the fact that, at times, tension can arise within communities between, for example, those who may be directly bereaved, may have lost family members, and communities who may be struggling with

broader harm. So I wonder if you can speak to that and to some best practices about making sure that everybody's taken care of.

MS. JACLYN SCHILDKRAUT: Thank you for that. I think we can't underscore the need for respect enough, and I've heard, you know, from so many of our other panelists who have raised so many good points about the need for acknowledgement of individualized circumstances within this greater tragedy. And I think one of the challenges is, is that rightfully so, oftentimes the resources are concentrated on those who are most affected, the families who have lost loved ones, those who were present at the scene, and first responders. In our country, those are typically labelled as crime victims. And what ends up happening is there tends to sometimes be a lack of acknowledgement of others in the community who are affected.

For instance, the people who may live in residences around the scene where it occurred, who may have heard or seen things, or people who knew others but weren't necessarily directly impacted. There's not enough acknowledgement oftentimes of the indirect impact. And I think to the point that Lev raised, it's so incredibly important to give individuals the space to voice their needs, because oftentimes, even when resources are offered, they are offered in a way that's not consistent with the needs, which to Grete's point, can perpetuate some of the psychological harms that people are experiencing. And so one of the, for lack of a better word, simplest things that we could do is create spaces for all affected individuals to have their voices heard and their needs met. And I think when that isn't being done, that's where some of that tension can breed because people may feel as though they have been affected but their voices aren't being heard, that they may be feeling silenced, or that their needs are not being met, and that not only produces additional trauma, but it produces friction, and it can further divide a community at a time where the community needs to come together. Thank you.

DR. EMMA CUNLIFFE: Thank you.

Mary, if I can turn, please, to you? I know that VOICES has also

navigated some of the tensions that can arise between the needs of different groups and different approaches. I'm very interested to hear you speak a little bit about how your organization has navigated these tensions and sought to address them.

MS. MARY FETCHET: Well, I would agree with what's been said. We started our support groups, which back to 9/11, we had to facilitate via teleconference call. Now thanks to Zoom, that's really opened up things for us. But back then, we divided -- we recognized the difference in the needs of victim's families. So we had groups for parents that lost loved ones, because they couldn't talk in front of their children. And then we had groups for siblings. We had groups for even firefighter mothers because they have a very different culture. And you talk about division at the time. I think there was a lot of turmoil because they -- the firefighters and the police that had died were recognized as heroes when many of the families felt that their loved ones too were probably helping people out of the building. So there were a lot of these tensions as people have talked about. And then we couldn't have witnesses, who saw things that no one should ever see in their lifetime, talk in front of the families, so we had groups for witnesses. We had groups for survivors. We had groups for responders. So we really defined it very specifically.

You know, I wanted to go back though, you know, to really the beginning. You know, you're two years out. Certainly, in the early days, the most important thing for everyone is to have accurate information, and you really have to think in terms of, you know, who's communicating that, how can you streamline it, so the right person is giving the right information. And that certainly always has to start with the people, if it's related to the death of their loved one, that's for the families. You have to take into consideration holidays, birthdays, the anniversary, and how are you going to support those people during those times. We saw after 9/11, I can't tell you the number of the deadlines that we had that were set around Christmas or around the anniversary when families were really just trying to garner up the strength to get through, you know, a very emotional time for them and their families. So that's something to think about.

You know, I think to Grete's point, we also did research on the long-term needs of victim's families 15 years out and have quite a few of the same findings that she talked about. You have to take into consideration other tragedies that happen and how is that impacting your community, when there's a shooting in Oslo, and they've just gone through two years of trying to recover. Oftentimes, people don't know what they need, so you really have to develop programs that are very innovative. We've started journaling workshops. We have webinars on all kinds of topics that might be relevant for one or all of the people that we're continuing to serve. Certainly, as was brought up, COVID is another factor, and how did the isolation and not being able to get out and be with people, when you're trying to rebuild the community, what impact has that had on somebody that's still struggling.

I think the one point that I wanted to make as often -- I feel very strongly if the resources and the information and the services are provided in a streamline fashion, that -- and there's a handoff, if you don't have the resource the person needs, you're going to connect them with somebody that does. And I think this helps mitigate the mental health complications that we've seen long-term because of, you know, the hundreds of organizations that were providing support with a lot of overlaps, the gaps that weren't filled and what was really needed. And, you know, and I think that the role of advocacy and giving back is another really important component to healing.

People lost their -- you know, they lost a loved one, but they lost a sense of control. And anything that you can do to provide that person with a sense of control, which really starts with engaging with them and making sure that they're part of any decision-making process that's going to impact them and their families, starting with the resources that they need, involving them in whatever commemoration that's planned, involving them in the memorial process, and helping them commemorate their loved ones in a meaningful way.

So I think when you take all this into consideration, it's really

meeting the needs for people that probably don't know what they need right now. So I think making things available and, you know, healing does start with the community, and I -- you know, my heart goes out to Serena and all of those who were impacted themselves with this horrible tragedy in your community and what support are they getting. You know, victim's families are not the friendliest people because they've gone through a tragedy that, in most cases, they -- we feel could have been prevented on some level. And so that investigation, getting to the answers of what happened, and holding some accountability, so that they know -- I think victim's families, first and foremost, they don't want this to happen to another family member. They want to do something proactive in a way that's going to help support, really understanding and fixing the problem, so if not preventing it, helping to mitigate, so that you don't have the major loss of life that we see in so many of these -- whether it's a school shooting, or a terrorist attack. You know, I think that we do feel that we want to have lessons learned, and we want to try in any way that we can, to prevent another mother from losing a child, or another whatever the family member is, from losing someone that was a really important part of their life and their family.

DR. EMMA CUNLIFFE: Thank you, Mary. And just to reassure the roundtable members and the audience, many of the themes that Mary's spoken to are things that we'll return to over the course of the round table today.

For the moment though, I'd like to stay focussed, if we can, on the concepts and the key ideas that we'll be working with. And, Terry, if I can turn to you and some of the key concepts in your research. Your research suggests that beyond the mental health impacts and the bereavement of experiencing a mass casualty, communities also experience an increase in physical ailments after such an incident occurs. And I know that both Mary and Grete's research also confirms that point. You and Grete use the term somatization to describe this process. Can you please explain what the word somatic or somatization means and why you use it in this context?

DR. TERRY MITCHELL: Yes, I will try. So soma, it means body.

So Somatization means that the grief, the pain, the emotional, the cognitive dissonance is stored in the body, manifested in the body. And so somatization is -- it can be -- can contribute, as you'll see in the Swiss Air studies, it can contribute as a risk factor to certain illnesses. And in the trauma literature, we know that respiratory diseases, cardiovascular diseases, gastrointestinal and immunological diseases, as well as neurological and others, are connected, strongly connected to PTSD or correlated to PTSD. But also as a psychologist, I would say that the tremendous amounts of stress and tremendous amounts of repression of the anxiety, the anger, the rage, the internalization as opposed to externalization with appropriate supports and vehicles, the internalization of rage, stress, anxiety can manifest not only in behavioural issues in pain and in dissociation, of separating one's mind from one's experience and one's body, that actually, that dissociative tendencies of repression of the anger, grief, sadness, rage can be manifested in illness. And in -- so somatization is the conversion of emotional and physical symptoms.

DR. EMMA CUNLIFFE: Thank you.

DR. TERRY MITCHELL: And in the Swiss Air disaster, a response of the very brave and heroic communities here that helped so many families recover what they could to identify the human remains that were recovered off of the shores of Nova Scotia, when we had access to pre data because of the public health system, we had access to health data prior to disaster, and then we looked at the disaster after one year and two years and we followed through, and we were able to see that before the disaster the ICD9 codes within the health registry were declining, that the incidence of certain diseases were actually declining, and then after the disaster they started to increase, but as was mentioned by another speaker, then they started to flatten out. And it was in year two that we saw the biggest -- the biggest peak in health, in cardiovascular and gastrointestinal and respiratory, immunological diseases.

And I want to mention at this point that somatisation, it can happen with happen with anyone. And so there's an -- there's an important -- in our data we

saw adolescents were affected. Even though they weren't on the boats, they weren't in the recovery efforts, they were strongly affected, as were people of low income and elderly people. So the whole community, as Jaclyn was saying, the whole community can be affected, not only the first responders, and that the somatisation can manifest very long-term health impacts for whole communities.

DR. EMMA CUNLIFFE: Thank you very much, Terry.

Grete, I'm going to turn to you. We've already heard a couple of times today the term "PTSD", and in fact, we've heard it a lot in the course of our work. But I'm not sure it's ever been defined within our proceedings, and I'm not sure it's entirely widely understood in terms of the set of symptoms that it describes and how ordinary people might understand PTSD and its impact on the lives and behaviours of those who experience this condition. I wonder if you can help us with that?

DR. GRETE DYB: I can certainly try. I think that people that are experiences [sic] these symptoms find them really scary. I think that it's scary to -- the first group of symptoms we call re-experiencing the event, and being in such brutal events that we are talking about here, is, of course, very scary, and people be -- are very upset when they have this re-experiencing. And that can be pictures, it can be smells, it can be noises that you hear, like banging or loud noises that will remind you about the shooting, of course, and also other things that happened during the event can be re-experienced in many different ways.

And that leads to avoiding these situations, and that you avoid both situations that resemble the situation you were in, but also, you avoid thinking about it and you don't want to hear anything about it. You see the newspapers, it's -- you don't want to go out because you're scared that you will -- you will see the front of a newspaper that would remind you of it. That can go on to be quite a big problem, and you can isolate yourself, and you know isolation and withdrawing from social situation is very harmful.

And then, we have this new group of symptoms for the DSM-5 with

its impacting your thoughts and cognitions so that you start thinking about that you will have a for shortened, for instance, or that you are a bad person because you didn't manage to do what you thought you should have done in the situation, all kinds of thoughts that are really not positive for your recovery.

And then the last group of symptoms is this heightened level of responses so that when you hear a sound you startle, you look around, you look out for dangers, you have difficulties concentrating, you are irritable. Well, we usually say that adults are irritable, children are angry, but I think, you know, adults are also very angry. And as I said, difficulty sleeping, nightmares. And that can be really disturbing, also for your daily routines that you don't manage your every day life because of these heightened responses that you have.

That -- that's mainly the symptoms, and they are all very logic. I think you all understand that this is a normal response to a very abnormal situation that you have been in, a high level of danger, and you're scared, and you maybe sometimes just barely escaped from being killed. And it's impacting you in many ways.

But having these symptoms can be really disturbing. Some youths think that they go crazy, you know, "I'm not going to be myself again, I have this very weird reactions to normal things", and it's very important that psychoeducation is part of what you offer them so that they understand these symptoms and then can respond more adequately to them when they get these symptoms.

And Terry was talking about the somatisation and the somatic symptoms that you often have, it's very linked to these psychiatric symptoms. And unfortunately, we don't really have treatment programs that treat both. We think that we treat a psychological problems, we may also treat the somatic problems, sometimes that's not enough. So we should have a more integrated treatment actually that actually try to solve many of these problems across soma and psychological problems.

DR. EMMA CUNLIFFE: Thank you very much.

Serena, Grete has just been speaking, among other things, to

mental health challenges that might arise as a result of experiencing a mass casualty. I understand that you have distinguished between the mental health impacts and the complex grief and bereavement processes that these incidents may also precipitate. Why should we think about grief and bereavement separately from mental health?

MS. SERENA LEWIS: I think it's critical that we delineate the fact that grief and bereavement is incredibly normal, it is necessary, it's part of a process that we've been going through for various reasons probably across our entire lifespan, but I don't think we have had great accessibility in North America to the language. So I have really witnessed a lot of struggle around death and grief literacy, and we've kind of lumped it all into mental health, which I think again proves a bit of an issue around how and what the support and education look like.

So we have to be able to think and talk about death in all of the various ways that it occurs in our lives, but I think the whole thing becomes when I think about the facts, and I really applaud, Grete, your discussion on the need for psychoeducational support because I think when I understand what's happening to me, I understand that trauma is a very natural reaction and it's -- given the exposure that we have been through, I think it's important that we can pull this apart to say how do we work with trauma in a proactive way so that people understand. And I believe that education is power, and when I can understand what's happening within my system, within my family, within my community, within my province, then I have a different kind of way to respond in my own healing process, but in understanding other peoples as well.

So when we can talk about trauma and grief, and the fact that grief affects us holistically in every aspect of us, you know, we're cognitively impacted and we're talking about this, right, how it's affecting our body, mind and psyche, we're talking about the physicality's of our losses. And I think now about the identity that so many people in these areas are working through right now about sense of identity and becoming one of "those" communities that are now lumped in with "your" communities

that we're researching, this is a big struggle.

So we're grieving so many aspects of this, and being able to have really well-facilitated discussions on what does this mean?

How are we finding peace through this? Or are we? How are we emotionally working it through? And how, socially, when so much has been disrupted in this grieving process, how are we going to recognize the need that as we can talk about grief, I've often said to people, is it grief? Is it depression? Is it fear? Is it anxiety? And does trauma necessarily have to become PTSD?

So again, I realize in all of the education that I've provided in my work experience, that when we can be proactive, that affects the reactivity of this.

DR. EMMA CUNLIFFE: Megan, what strategies do you use to foster these conversations in the communities that you work with?

DR. MEGAN McELHERAN: M'hm. I want to just pick up off some of what's been discussed here and then I will -- I'll go into that.

I really appreciate this commentary around let's be careful not to pathologize that which is actually very normal or very natural or expected when this type of an experience happens.

When I look at the literature and the research and my clinical experience about how people recover from traumatic events and how they are able to come to a place where they reclaim a thriving in their lives, there's a couple of things that are fairly common place, or that commonly happened for people.

When a tragedy, when a trauma of this nature of this scale happens, the natural reaction is to feel horrified, and devastated, and terrified. And the natural reaction is for that to disrupt and destabilize things. And that doesn't just go away overnight.

But actually, as a human species, we have an incredible capacity to recover and to heal and we actually see that apart from, you know, certain conditions, which I'll speak to in a second, many people are going to go through trauma in their

lives, but most people are not going to go on to have a persistent post-trauma reaction, because we seem to have natural or adaptive ways to recover from trauma after it happens, if the right ingredients and the right conditions can be put into place.

When people -- you know, a comment that I think is very true for organizations and communities where an act of violence or a mass tragedy happens, when people start to get into a way of thinking or a way of being where they -- I think of it sort of as trauma relativism. "I don't deserve to feel this way because it didn't directly happen to me," or, "It's worse for other people," or "I should be stronger than this. I need to be the strong one for my family. Therefore, I can't let myself feel this." When we start to do that to ourselves, whether at the level of individual, in family system, in a community, what that does, potentially, is it interrupts that natural process of recovery. And oftentimes that is where we start to see things get stuck.

And so those symptoms that Grete was talking about, those are the kinds of things that can persist. The symptoms themselves are perfectly natural reactions. What we're talking about is what happens when those sort of become stuck and become, you know, become avoided or disconnected from, again, because individuals, or families, or communities conclude that they shouldn't allow themselves, or shouldn't have these things.

So what are some of the strategies? I humbly and firmly believe and advocate and deeply recommend that everyone in the community and anyone who has experienced this type of event, regardless of how near, or close, or far, or distanced you were from the kinetic things that happened, give yourself permission; right? The strategies are we need to understand that we create misery when we try not to have something that we already have. So if I try to convince myself that I shouldn't feel a certain way, or other people need me more and so I shouldn't be asking for help, I shouldn't be reaching out to have conversation, when we start to put those kinds of rules in place, oftentimes that's where we see some of the post-trauma disturbance persist.

So, you know, when we are in pain, a very natural thing to do is to want to pull away from it. And, you know, when we think about our emotional pain, oftentimes that means we want to pull away from those who are around us. And the call to action and the most significant strategy is to find ways to take the pressure off of having all of the solutions or the answers to the problems that are being faced, and to just take daily risks of trying to be open, trying to be willing to self-disclose, even to a slightly small degree, how we're doing; right? To be willing to ask questions of each other without fearing that if I ask the wrong question, I'm somehow going to make this worse for the person, and therefore I won't ask anything at all; right?

So the strategy -- the number one strategy is we have to maintain a focus on engagement and connection, and leaning into, not pulling away.

And I think that shows up in any number of different ways; right? That shows up, first and foremost, with how we are with ourselves. And so I would invite everyone who has been impacted by this experience to acknowledge that any amount of feeling, or thought, or pain that is accompanying this experience simply needs to be met as being part of your experience and that that requires validation, and that from there, if we can be doing that with ourselves, we might be more inclined to do that to our friends or our family members, and then that might actually create norms within the community about how a community is going to heal together.

I want to just finish and I'll move on, as I'm sure you have other people to go to.

I really think it's important, particularly for the community and the families right now, to understand that because of how, you know, extreme and significant, because of the degree of loss of life, because of this happening in covid and all of the impacts that had in being able to come together, because of the Inquiry, because this is still going on in many ways, I equate it to a soldier on a battlefield. We can't recover from the trauma of the battlefield when we're still on the battlefield.

And so in many ways, it isn't until there can be some degree of, you

know, recognition or a place to come to where the media attention, the scrutiny, et cetera, has maybe died down. It's really then where the community can come together and go, "Okay. How are we going to do this together?" Because maybe we're on the other side of some of this and we can actually start to do this in connection, in relationship with one another.

DR. EMMA CUNLIFFE: Thank you.

Commissioners, I'm about to move on to a new topic. Would this be a good time to take 15 minutes?

COMMISSIONER MacDONALD: Yes. Thank you so much, Dr. Cunliffe. And of course, thank the panelists so much for their generous, important, and helpful insights so far. And we'll break for 15 minutes and of course hear more.

So thank you.

--- Upon breaking at 11:14 a.m.

--- Upon resuming at 11:21 a.m.

COMMISSIONER MacDONALD: Emma?

DR. EMMA CUNLIFFE: Thank you, Commissioners.

Okay. As we reconvene, I'm now going to take the roundtable members through a series of discussions that are organised around the timescale of mass casualties and responses, reactions to mass casualties. And I'm going to begin with the immediate needs of survivors and communities who experience a mass casualty.

Grete, if I can turn back to you. You used the term "psychological first aid" in your report to describe the immediate needs of those who experience a mass casualty incident. What does this term mean, and what does psychological first aid look like?

DR. GRETE DYB: You know, we don't really know what people need immediately because we never actually studied it reasonably. So psychological first aid relies on a lot of common sense and a lot of what people have told us that they

felt that they needed. And we had a lot of other responses before, for instance, debriefing that was used a lot. That is not recommended anymore because we think it might be harmful for some.

But psychological first aid is, first of all, to realise that people's emotions are very strong, and that they need to stabilise their emotions so that they get less scared and more get themselves together and understand what is going on with them. It's also to give them reasonable amounts of adequate information about what has happened, because their memory is very fragmented after an event like this and it's very frightening to not understand what has happened to you and to people around you. So information is very important.

And then also, to give them what they need of support. Some people when, you know, after the shooting at Utøya, they -- many of them were swimming in the cold water, they came over, they were wet, they were cold, they were -- you know, they needed warm drinks, they needed blankets. And then to help them to reach out to their close ones, because getting them in connections with the people that they trust most will give them a sense of that they are safe and that, you know, that they are able to reconnect with the people that can give them support and calm them down better than any of us can do, so that's important.

And also, to -- also to reach out to friends, and a lot of other of our survivors and families, they used social media and of course cell phones. They didn't have cell phones because they were lost in the -- in the tragedy, but to help them to reach out, use cell phones or social media, that was what they did, and I think that helped them a lot.

Because with a mass casualty, people try to come to the site, and it's usually jammed with ambulances, firefighters, whatever, you know, and it's hard to get to the site. Even though parents and families wanted to come there to support them and help them, that was difficult. So now we have all these other kinds of instruments that we can use to reach out. I think that's important.

So as you can hear, it's a lot of common sense, but it helps people stabilise and understand what's going on, giving them kind of a meaning of what has happened to them, and also, reassure them that people who are safe, that they assure that they are safe.

And sometimes, when people have been after them, like this shooter, they have also difficulties in trusting helpers. He was disguised as a police officer, and so when they saw anything that resembled a uniform they were totally freaked because they thought it was a terror attack that was much wider and more attackers. Even in the hospital they had difficulties trusting nurses because they thought that this was a much broader thing that was going on with them. Many of these were going in and out of consciousness, and that also confused them a lot.

So that's the very common sense but very important things that we -- message that we have to take in the immediate aftermath, and usually that happens in the emergency centres or where people gather after an event.

DR. EMMA CUNLIFFE: Thank you very much. Grete, I know that one feature of the Norwegian approach is to utilise multi-disciplinary crisis teams to reach out proactively in the -- in the days after a mass casualty happens. I wonder if you can describe those teams and the work that they do?

DR. GRETE DYB: I think many of my colleagues here have also talked about how important it is to be proactive. I think some said that people don't know what they need, and when they feel that they need something, they don't know who to reach out, they don't know who can give them this help.

So we have ended up doing proactive approaches, both after the tsunami disaster in 2004, and then after the terror attack in 2011. And every municipality has a crisis team that reaches out to family in acute crisis. Usually it's accidents where people die or suicide or other acute events that were not in any way -- that they didn't expect happening. So it's usually a medical doctor, a GP usually; a psychologist, if they have one, if they're lucky to have one; a nurse; and a social worker.

That's most often the team. They have other jobs in the municipality, but they have signed up to be on the crisis team so that they can reach out, you know, if it's a evening or even at night, if it's very acute.

And they do a lot of this work the first day after an event happens. And I think many families who have had these acute events happening and, you know, tremendous grief, for instance, we have had fires where whole families have died, and then the extended family, they -- the crisis team will open churches or other places where they can come.

And then after that, it's more up to the municipality on the primary level of healthcare that is supposed to follow up that work. We're not so good at that, but I think with the crisis team after the tsunami in 2004, we saw that only half of the families had been contacted by the crisis team. I don't think that all crisis teams were familiar with the proactiveness that they needed to do, and after that, we passed actually a law saying that all municipalities must have a crisis team. And after that, there's been done a lot of training, and I think it works pretty good. In our case, I think about 90-percent of the survivors said that they had been contacted by the crisis team.

DR. EMMA CUNLIFFE: Thank you.

Levent, I know that you have thought about how societies, governments, communities can prepare to provide immediate support when a mass casualty incident happens. What kinds of preparedness should be in place before the event even begins?

MR. LEVENT ALTAN: Thank you. Maybe I'll just go on to a little bit more about what Grete said because she started off by saying "we don't know", and then she went on to say how much we do know. This is particularly important. And I've spoken to numerous parliaments recently in the UN and other places, and the first thing that I say to everyone now is we do know. There is no excuse now to say we didn't expect it, and we didn't know what to do, and we didn't plan for it.

I think "we don't perfectly know everything" is a different issue, and

there are also some nuances about how you do things, and I think particularly when you talk about psychological responses, it gets complex and you need multiple different tools, really, to be able to address the different situations of each individual. But from a policy perspective, from a legislative perspective, we know a huge amount.

Since 9/11, we have seen countries around the world go through many, many terror attacks and many mass casualty incidents, and have developed lots of solutions, and we have UN modelled provisions which explain a huge amount of the structure of how to do these things, and we have countries like the UK, Spain, France and U.S. and others that really have significant systems in place.

So I think that's really important for everybody to understand, and all of the data that we keep talking about it's fundamental because it is easy to say there isn't the data, or it's say something else is more important or something else is more -- is less costly. The data shows that not responding appropriately is the most costly thing to do in terms of health impacts, in terms of economic impacts, in terms of fundamental rights, in terms of your community cohesion and residents. So I think it's important to always come back to that, that we know and we have to act and we have to plan.

In terms of your question, it -- I think there are many, and this is quite a unique -- an amazing -- office of -- from the DVI Victim Services, who said, "most actions are predictable and can be planned for", and that's the case in this field.

In terms of the planning and preparation, you've heard some of those things before. There are pieces around, first of all, what do you need to do in the crisis and what procedures and protocols do you now need to have in place?

We know that the -- some of the best solutions, you heard about multi-agency centres, victim assistance centres, a place which is set up where you can host family members, maybe (inaudible) and others, multi-disciplinary so you can provide the kind of information that they need, but in order to do that effectively, we need local planning in place so that you know where would you set it up, how would you operate it, who sits where, where do you get the food and other kinds of emergency

materials that you might need, for example. You need to plan all of those things, but you also need to build the relationships. We heard about trust and the long time it takes to build relationships. That's fundamental to the effective response. These kinds of scenes are extremely chaotic, you need to know who needs to do what, when they need to do it.

We all have our counterterrorism disaster response planning, what doesn't seem -- isn't -- doesn't tend to be so well incorporated into that thinking is the victim perspective, and who, from a victim response perspective, should be there, when, how do you combine civil society and the state responses together to have the most effective framework for response.

So you need to have planned where your support is coming from, who is providing that support. The nature of the support will be slightly different in that crisis phase, but you also then need to have the planning for the transition into the longer period, but you also need to have the communication frameworks in place.

It was mentioned earlier, I think it was Mary, who talked about information. It's not only is a conduit right in the sense that it helps you access other services and rights, but it's fundamental to a person's understanding of what's going on. It can reduce harm or it can increase harm, depending on how you handle your communications.

As an example of how not to handle that kind of communication: After the Brussels attacks, the identification of the murdered victims was taking place, and the decision was made, out of the concern for the victims themselves, to not inform family members of the identification of the victims until they were absolutely 100 percent certain. And in one case, the family members were going around hospitals for days looking for their loved one, whilst the coroner or the DVI experts had known 90 percent who the person was. And the trauma of knowing that this -- that the person knew 90 percent and they were still seeking their loved one was extremely harrowing for the family members.

So there are other ways of being transparent in informing victims about the situation, about communicating, and that's communication with the public, in general, and then having the communication procedures in place so that you can effectively communicate with the victims as well. And within the concept of communication, within that framework, you're looking at fundamentally how do you communicate, different methods of communication, so different formats, so that you're taking into account the different ways that people will absorb that information, ensuring it's simple and accessible, that it's repeated.

We keep hearing this point about proactive as well, and that's proactive in terms of offering support, but also proactive in terms of providing information. People in these traumatising, chaotic situations, don't know what they want when they need it. We need to keep offering those things in an appropriate manner at different times and in different ways, and that's a fundamental part of the way that we communicate.

So communication, you can prepare for and plan for. You can have a lot of the procedures and processes in place. You can even have the structures for a public website.

So in the Netherlands now, they're able to set up a victim-focused website for a public and a private area for the victims within a matter of hours, because they know their fundamental architecture for the website. They have a contract with Victim Support Netherlands; they have the funding in place. Now, the content may be -- have to be adjusted slightly for any given case, but they have that funding prepared for already. So they know what they need to do and how to communicate it.

The link to this training. So in training in many different ways. You need to -- well, before I go on to the full part about training, training is not a solution in itself. You need to ground that training. You need the tools and mechanisms to support the people who are implementing that training. I think this idea that you can train someone for four hours in a one-off project-based training and expect them to suddenly

change and know what to do is unfeasible. I think you need to combine that with the tools.

So you need different kinds of training. You need training on what your obligations are as an officer, as an NGO, as a psychologist, where you fit within the system. You need to pressure test that -- those responses as well. It's not enough simply to know that you need to be put under pressure and to work out how to do it.

And I think it was after one of the Danish attacks that this was a recognition of victim support. They had all the procedures in place. It didn't work like that in practice, under the real pressure of the attack, and they had to learn from that and had to then test their procedures as well and test personnel in terms of how they respond to that pressurized situation.

That training has to be multi-agency as well. You need to have the different actors involved, working together as part of that process. And this tends to be -- it tends to work well when it comes to the, say the counter-terrorism or the law enforcement part of it, or the immediate health aspect of it, which may include the Red Cross, for example. And they're really focused on health, and hospitalization, and maybe countering the threat, the victim element to this, in terms of the emotional care of the victims in terms of setting up those centres and making sure that they're informed in a correct way, that tends to be forgotten or missing in some way.

So those are some of the aspects. Actually, there are many other aspects. I think one which I -- which is really important is the identification registration of victims, which could also be planned for and which doesn't necessarily go particularly well. And there are two elements to this.

One is actually having the systems in place to effectively record who are the victims and who are those impacted at the scene, knowing what kind of information you need to record. This whole system is fundamental to getting people into the system, recognizing that in an open attack of some kind, a lot of people will go home or go away, won't recognize that they've been affected in some way. And so -- and

that's not something you can put in place at the moment the attack happens. You need to have the systems in place.

Here in Belgium they've learned their lessons around this. They now have an amazing technological solution called Be Prepared, which includes a bracelet and which has wide ranging information that can be input. They also have the data sharing procedures in place.

Data privacy is extremely important, but it often inhibits the ability to share information between agencies, which is legitimate to share. So the procedures, protocols, and laws to allow that to happen have to be in place. The infrastructure for the recording of who is part or affected, and the understanding that this information is relevant not jut for this crisis phase, but for the long term is extremely critical.

I think -- I won't go on to too many other examples, but I think ---

DR. EMMA CUNLIFFE: That's really helpful, Levent. Thank you very much.

MR. LEVEN ALTAN: Okay.

DR. EMMA CUNLIFFE: I do want to just let the Commissioners and Participants know that many of the recommendations Levent has just shared with us are contained in a report that he produced on supporting victims of terrorism, which we will arrange to have tendered before you.

If I can turn, please, Jaclyn, to you? One of the things that your report touches on is the impacts of the media in the very early hours and the impacts of media scrutiny and interest on the experiences of those who have survived mass casualty. I wonder if you can speak a bit to that?

DR. JACLYN SCHILDKRAUT: How we see mass casualty events unfold today is not always the way that it has been.

The first time in our country that we ever saw it unfold the way that we see it now is with Columbine, and that was purely by chance that the media were about 40 minutes away covering another very major national story when the news of the

shooting unfolded. And so it was very quick that they were able to get down to Littleton to cover an event that, today, would not be in progress for that long, in most instance, or at least in our country, but was still ongoing.

And the challenges that we see are numerous. The first is that there's very, very intensive media coverage in the first minutes, hours, days. In our particular instance in our community, they were still pulling kids out of the schools, trying to get them to their families, and the media were putting microphones in their faces and asking them how they felt, when they didn't even know if they were ever going to see their parents again.

And so every moment of that immediate aftermath is covered, from extrication of the buildings, to family reunifications, to funerals, to community vigils, to memorials, and then sort of whatever the next steps are whether it's for children going back to school or one of the things I think about with Buffalo is they're going to open that supermarket again because they need to, and so the supermarket reopening will be something that is media covered.

And what ends up happening is while individuals are trying to process the incredible amounts of trauma that they have just gone through, they are doing it under the glare of a spotlight.

And some survivors have likened it to -- I think about one parent who lost his daughter actually in Columbine, and he talks about his grieving in a fishbowl, where there's this giant light and lens on you and everybody is watching you and you become a commodity, in a sense.

And then what ends up happening is it becomes almost this surrogate support that you feel that everybody can be really with you because they're all, you know, supporting you vicariously through this lens, but eventually the next big story comes along and the cameras leave. And then now you've taken a community that's already lost so much, and then they feel left behind.

And that presents a lot of challenges for that grief process because,

you know, one thing that I think we've tangentially touched upon, but if I may speak so forthrightedly [*sic*] -- I'm not sure if that's a word -- is we talk a lot about normal, but for survivors, they don't go back to normal. They go to the new normal and they have to figure out how to navigate a space where the rest of the world gets to move on and the rest of the world goes on to tomorrow, and the next day, and they're still trying to figure out how to put one foot in front of another.

And so the intensive media coverage and then subsequent removal of those cameras can very much be a secondary loss and additional victimization.

And I think one thing that we also don't necessarily consider is, you know, when people come back for year marks or other events, we had multiple losses in our community after the initial impact, or when the first-year mark came, or, you know, other things. You can't keep coming in and out of people's lives while they're trying to process all of this without respect and care for how they can handle that. And we need to ensure that we're not using those who are affected as a means to an end. We certainly want to get information out there to everybody, but we don't have to impede on people's grieving processes to do that.

DR. EMMA CUNLIFFE: Thank you very much.

Terry, I think this is probably a good moment to turn to a conversation that you and I have had, which is -- I think really builds on the insights Jaclyn has just shared. The importance of providing community members with safe spaces to express anger, rage, to process in ways that may either be subject to sensationalization, if they're covered within the media or to condemnation by those who don't understand. I wonder if you can speak, based on your expertise about trauma, about why that's important.

DR. TERRY MITCHELL: Well, earlier you had asked me about somatization. So repression is repression meaning trying to keep everything down and not bring things to consciousness or be so traumatized that one is actually dissociating, meaning that one's conscious awareness is separated from one's emotional life, and

that you're kind of living outside of yourself. And that contributes to the repression. And if we don't support individuals, and in this case communities, like, whole systems, individuals and families, whole communities, even all of Nova Scotia, to acknowledge what's happened, to be able even to not move on, to not forget, to have a place as individuals and families and communities to have a voice to that pain and to that anger and to that rage.

What I was mentioning earlier today, no one wants to live in anger. No one wants to live in rage. It doesn't appear to be a healthy goal, but the type of mass casualty that we're talking about, there are kind of three different characteristics of mass casualties. The natural disasters, which we have more and more, and trauma and destruction of environment, and terror, and terrible things that are happening to those communities and to our own communities, to a technical event such as the Swiss Air disaster. It was unanticipated, and it was horrific and traumatic. But there was no one -- in both of those cases, there's a way of making peace in some way with the event. But with a violent crime, with a terrorist event, with a mass casualty the nature of many that we've been speaking about where people are chased and gunned down, or attacked by airplanes, the unimaginable, what is happening now is the unimaginable, where we as humans are having existential crisises *[sic]*, where there are heightened levels of risk, an extreme sense of enduring lack of control, and a focus on the fragility of the human condition. That's unimaginable and hard to mitigate and manage on our own. That's why people talk about community and connectedness and being able to revisit this, to have the permission to have voice and community and support to acknowledge the nature, the horror of what happened, that it was unpredictable, that it was unexpected and it was beyond the tolerable range of human experience, that this is an existential crisis not for one individual, not for one family, not for one community, for many communities, for province, for the country in some regard. And that we don't -- we can't ask people just to politely move through their grieving. We need to be able to support people to actually feel what they don't want to feel, which is tremendously

enraged. And not everyone necessarily will process that way. As we've mentioned and others have mentioned, that everyone will go through a process differently and different times. But there is a place for justified anger and for reasonable rage about unreasonable events.

And so in linking to we will have better health outcomes if people are given safe places and structured ways to tell their truth, to tell their pain, and not in polite ways, but in real ways, in embodied ways of what they lost, and how much it hurts, and how it shouldn't have happened. And so there's more about that, but that's about creating spaces, as people have talked about, safe spaces to have voice, to speak truths, to validate their emotions, and the full range of emotion.

As Canadians and as humans generally, we're not really great at death and death language, grieving language, and we're not really -- myself in particular, not good with conflict and anger, but these are times, important times to be able to reclaim that as human beings and validate justified anger, rage that's reasonable according to an existential crisis. And that I will link to reduce somatization, more people being able to reconnect their thoughts with their emotions, to reconnect and to move towards coming together again, and coming together to do this, and then coming together to integrate the self and integrate families and communities again.

DR. EMMA CUNLIFFE: Thank you.

Serena, we've heard a number of allusions to the ways in which the COVID-19 pandemic and associated public health measures may have interrupted some of the kinds of processes that have been recommended or discussed today. I'm wondering if you can speak to your experience of how the public health crisis has played out with respect to the capacity of the community that you're a member of to process what has happened?

MS. SERENA LEWIS: I think this will definitely add a whole new lens to our research angle when so many of the strategies and things that we talk about -- Levent, I was just thinking about all of the things that you also has *[sic]* mentioned,

and Grete, about what we would normally do around communications and gatherings and how much this has been disrupted. Processes of rituals, and funerals, and memorials, and all of the acknowledgments of the anniversaries that we've already had to face over the last couple of years that are very much from an individual perspective but also from a community, and a broader scale I think across the province and country.

It was interesting, I want to pay attention to something that was said to me yesterday, because I think it's important that we lean on language around resiliency. And during a pandemic where we have been isolated and trying to follow public health measures, I think that this has added a whole new layer to what has occurred here, which heightens the reason that people are almost living through two traumatic events in these communities, and therefore, require a lot more. But somebody said to me, which I found fascinating, are people getting their resiliency on us or are we just becoming silent, and is that the expectation now? And I know as I have been talking through this, I've leaned on research and reading a lot of what I would like to call my colleagues at this point, and talking about the impacts of stoicism, which I think really gets misconstrued in a rural, and I think we have to incredibly remember the small c cultural context that this occurred in many communities, not just one, but in many communities with rural context, that that stoicism, and then when we added a layer of a hashtag of Nova Scotia Strong, I got very scared. I will be very honest about that, because in all of the work that I have done, strong and grief and trauma don't mix well. If I can use the hashtag Nova Scotia Strong for the connectedness that I wish we were experiencing through this and the coming together in ways that we could have, but that's not how this plays out sometimes. And I think in that Nova Scotia Strong and leaning on -- I know, Terry, you have talked about the impacts of Swiss Air. Stoicism and people leaning on their own ways of trying to figure out how to semantically -- and I think again, I'm not sure that a lot of people have actually even had an ability to start to process this. So the isolation combined with the grief and the trauma, well intentioned, but a hashtag that shut us down more, has been deeply concerning for me.

So the pandemic has added a lot. I have felt, in many ways myself, handcuffed at times from the things that I would like to have been able to do, and attempted to do, along the whole pathway from the night, the morning, and for the last two years.

Again, I applaud -- when you talk about the media, I often have said in education we need to keep the casseroles coming because that is one of our strengths as a Maritime, rural connectiveness, but we miss the casseroles, and we haven't really received them, I think, in the ways that we needed to.

And as the media changes and evolves and tries to work with us through this, I think it's added a whole other lens of sometimes exploiting our grief in ways that have become very disruptive and painful for people as well.

So this pandemic, I, again, really am hopeful that this does not become the excuse to do what we need to do. I think we have to recognize it as a double impacted trauma on our province, which leans more into recommendations moving forward into the future.

DR. EMMA CUNLIFFE: Thank you.

And for the record, Terry's research that Serena has just referred to, is before the Commissioners as Exhibit P002623.

I'm going to shift gears a little bit now and pick up on something that has been alluded to a number of times in other conversations this morning, but I think it bears surfacing and discussing in and of itself. And this is looking beyond the mental health, bereavement, and even physical medical needs of those affected, to the other needs that survivors may have, particularly for information, for truth, for a sense of control over what happens next.

Mary, if I can begin with you on this question? What is it that you've observed in your work since 9/11 about the needs of those most affected for these kinds of support of services?

MS. MARY FETCHET: Well, I mentioned earlier how important it is

to have the individuals involved, and at every level to have the information, no matter what it is, that's related to them. And then to engage them in the process, and we saw that firsthand in the long and arduous process of creating a memorial, which took 12 years, in New York City. All of the stakeholders were part of that process, and each of them had, at the beginning, very different visions for what the memorial should be. But over time, you know, we came to an agreement.

And so I think the process of so many of these things, you can't evolve -- you can't avoid the conflict. You know, there is conflict in coming to agreement. So I think it's having that trust and respect and the continuity that's so important.

With regard to the 9/11 Commission, I mean, we were just reading the *New York Times* and seeing that the FBI knew this, and this didn't happen, or, you know the agencies weren't communicating within or among the agencies. So I think, you know, just normal citizens, 12 of us, going to Washington, D.C., and meeting with our congressional offices, and giving a voice to the people that died so tragically that day.

So I think that's another way that families can -- that's another way that families or community can be involved to really have a clear understanding of what happened. And then moving forward, many families become involved in other ways. I mean, they do different things to commemorate their loved ones; you know, to honour their life by supporting other people.

If I could go back, though, to your discussion about lessons learned, I mean, the psychological first aid was really developed because there are so many volunteers that are involved, which then led to the development of family assistance centres.

The communication and information that's provided to the families at that point, you know, they're in shock and they're in the middle of, you know, planning funerals and, you know -- and they're not able to really understand things or remember

things. So I think the important thing there is to really develop materials that can be distributed, and how do you talk to the media? You know, how do you plan a funeral? How do you -- you know, what agencies are available and what kinds of services are they providing?

And then, of course, the big gap for us, and probably for many other communities, was once a family assistance centre goes, and American Red Cross, who has the list of victims and the contact information, goes away, how do you transition that care and resources that families need, and how do you engage them in some of the processes; planning, commemorative events, honouring their loved ones, or becoming involved in other processes that affect them over time?

DR. EMMA CUNLIFFE: Thank you.

Grete, if I may turn to you? One of the really striking findings of your longitudinal study is the persistence of need for financial support, material support, educational support for survivors of Utøya and their families.

I wonder if you can speak a bit to what conclusions you drew from your research about the material and educational need of survivors.

DR. GRETE DYB: I think that we already knew from the tsunami disaster that, where so many families came back from -- mostly from Thailand and they returned to school, and we had this experiences with the schoolteachers really needed help. We lost 26 children down there and many of these families had lost a child. And we realized that the educational system, they are good at many things. They are good at providing help with children with ADHD, with children with disabilities; I mean, they learn a lot of that, but they were not having a clue about what to do with children who had been exposed to a disaster. And we knew from that that they also needed help when it came to the terror attack and what's happened after that.

But still we saw that, you know, after a couple of months, educators still were not understanding that this took time and that different schools did different things. That one school could be really good at it, doing all the things that they were

provided help for, other schools did nothing.

So we still have a long way to go in including educators in understanding what trauma is, what a disaster like a natural disaster or a mass shooting, how that impacts the children over time. And a simple thing like these terror survivors, they couldn't sit in the classroom without being very close to the door. And if -- they preferred to have the door open. They preferred to have an escape route, you know, where they knew that they can get out.

So that's the kind of thing that's really not easy to understand, maybe, for the other children; the teacher might think it's a little weird, but for the survivors, it's logic. They need to know that they are safe. And many of them couldn't bear it, you know?

And then it's the concentration; they have, you know, limited concentration span, so time -- the time spent that they can be concentrated is limited. Some of them need to get things read for them instead of reading it themselves.

So that can be all kinds of different tools that they can use, that's actually used already for other kids. But instead they become what I call -- maybe it's not so nice to say it, but mini-psychologists.

So educators are not psychologists; they are not psychiatrists. They shouldn't be. They should be educators helping them with tools, measures to help them to learn, you know, and of course, empathy and understanding what they are going through but instead, they said, "Well, I feel so sorry for you; can just go home." And what's that? And being at home, being isolated, that's not what we want them to. We want them to come to school, be with other children, other adolescents, and then little by little, come back to school to learn. But they mostly need that the educators understand that they have to design a protocol for them that is useful in their situation and imagine how important that is for a child to cope in this situation and being able to learn and not having the experience of yet another loss, the loss of proceed with their peers to graduate, you know. So there is -- there's amazing lot of work to be done

there.

And also for the media, you know, we've done a lot for journalists, both before this happened, during the years after the terror attack, and still, we are having seminars with journalists and trying to help each other to understand how we can both cover these events and getting the information out and taking care of the people that are the survivors and their families in an adequate way. It's not easy, but it's -- there is no one easy solution to it, and especially, you know, the concern from parents when it's a child involved and all that, they've done a lot of bad things, children, but they are learning, and I think we also have a task there.

DR. EMMA CUNLIFFE: Thank you.

Terry, one of the things that you emphasize in your research is the need for the communities who are affected by events to be involved in research about them, in helping to decide what happens next, and how an incident such as a mass casualty or disaster is responded to. Why is that so important?

DR. TERRY MITCHELL: It's essential. It's not only important, it's essential because it is their experience, it is their lives, it is their health that's at stake, it is their -- it's their grieving, it's their community, it's their future. And in my experience in working with various communities, Indigenous, and here in Nova Scotia, and communities in Nunavut, et cetera, I'm the outsider. Experts are generally the outsiders. Researchers are generally the outsiders. Specialists are usually the outsiders in rural communities, and rural and remote communities. And so we may have -- me, we may have knowledge that could have utility. We may have skills. We have essential resources, financial, medical, infrastructure, et cetera, that are essential also, but they have limited utility and create -- may create harm when we are relying upon our limited outsider knowledge of the community, its social structure, its environmental, physical layout, the relationships, and as I mentioned before, who has the leadership, who is trusted, and what are the capacities that are there.

A danger of not having communities lead is that communities have

strengths. They have strengths before the disaster. They have strengths during, and they have strengths after. They have capacity before, during and after. If we bring in a lot of experts, we then have the risk of not knowing what the heck we're doing. As you will be told often by community members, as I may be told often by community members, we don't know what we're doing, and because we don't know where we are, and we don't know who we're with. And how can you be effective if you don't know where you are, if you don't know the history, you don't know who you're with, and you don't know their priorities and their processes of how things work. How do you get something done in this community? How do you get people to come to a meeting? Go try to have a meeting in a northern community, an Indigenous community, or here in Nova Scotia by just putting a poster up or putting a bulletin out and just see how effective that is, because people on the inside of the communities know how to run a meeting, how to get people to come to meeting. And so community members are essential, strategically, pragmatically, but ethically. And if our objective is to benefit, to understand and to benefit, then community leaders and community members need to be at the helm of that ship.

And in health promotion literature and wellness literature, cardiovascular research, for example, we have been talking about community champions for many, many years, knowing that communities have capacity. So community champions such as Serena are gold. She holds the key and others like her in their communities who have -- are insiders to the community, they have the key to many things. So if your intention is to understand, speak to people in the community and build relationships, it might take you two years, but build relationships in order to find out who you may speak with and how you may speak, to what purpose, and then build alliances.

Part of what I was saying in there is that there's not only -- like, in -- it's mentioned briefly in one of the Swiss Air disaster things, but they talked about resources, not just media coming in and overwhelming. In one community, 500 military

were based there for over a month. Two hundred (200) people live in the community. Five hundred (500) military came into Peggy's Cove and established themselves. They can be overwhelmed. So that's not what I'm meaning to speak of though is that rather, we can create harm. You will see that people came to respond, disaster experts came to respond, but they didn't consult with the community, and they provided services that didn't fit, and people were, like, not trusting. What are all these mental health professionals in here and what do they want from me. And so being further defended against them. And then if they developed some relationships and they did provide some services that may have been of benefit, because they weren't from the community, they didn't live near the community, didn't work with the community, weren't part of their institutions, they then left. And we heard over and over and over again that the support that's required is not one day. It's not one week. It's not one month. Now we know it's not 1 year and it may be more than 10 years.

So if we work with community members, we don't want to undermine the capacity that's there. We don't want to replace the expertise that's there, the mental health professionals, the clergy, the response personnel who are there that know and understand and are committed to their community. We want to work with them to augment what they have and let them tell us what we need, what they need rather, and what we need in order to help them, what they need, their priorities, that may -- that we will meet fewer stumbling blocks if we work with community members on their terms, in their timelines, in their preferences, in their culture, with the people and the processes that they accept.

I know, blah, blah, blah, blah, blah. I could go on, you know, for hours. Apparently, I have already, but the experts are in the community. If we go in with experts, we undermine the capacity that's there. What we want to bring is experts that have permission and the consent to support and work with community priorities. Because what happens in traumatic events is that people lose sense of control. Something is happening to them. From a psychological perspective, people who are

traumatized don't need more things happening to them, things they feel like taken away, or done to them, or fixing them. They need support on their own terms. And they're the experts on what they need. And they may not be able to articulate that, but if you build a relationship, they will come to articulate what they need and how you might best support them to do it. And if you build capacity within their communities rather than big, deluxe, we'll bring in a whole bunch of resources and then they'll be gone, if you can build resources that are led by the control, the point is communities need more sense of rebuilding control, rebuilding safety, rebuilding a sense of competency and capacity. So if we fund and support infrastructure and supports within community that directed by, informed by, increase the sense of community control, they're as more likely to be a success in anything that we ever try to do.

DR. EMMA CUNLIFFE: Thank you very much.

Mehan, if I may turn to you. I know that you've worked with communities who experienced traumatic loss, in some cases many years before you start working with them. What can happen to a community over time if they haven't had the opportunity or the knowledge to begin to heal collectively or to build the kinds of capacity that Terry is alluding to?

DR. MEGAN McELHERAN: I want to -- appreciate what Terry just said because I really -- I was just nodding along as she was speaking. I have a dear colleague who has this idea of "nothing about us without us", and I think Terry did such a nice job of speaking to that.

I'm going to think about one community, in particular that I have worked with, where they had a very serious, very violent event happen, just about 30 years ago at this point in time, and my work with them has actually started in the last couple of years. And it's -- it refers back to something I said earlier in our conversation, which is when things are not confronted, when there's not proactive ways and supported -- supportive ways to help communities and community members work through a violent experience when it happens, it honestly is like the mosquito frozen in amber. And

communities that I have worked with, where there has been a historical traumatic event, in many ways it's as if the community has not progressed or has not moved forward from that story.

And this community, in particular, that I'm thinking about, what's happened is that there has ended up being quite a degree of schism between certain groups of the community who, you know, had ideas or thoughts about how to move forward in certain ways that other members of the community disagreed with, and what that, you know, facilitated or cultivated 30 years ago was separation. And so present day, currently, this story and the narrative and the old hurts are alive and well.

And so, you know, what can happen when the kinds of supports that are being sort of described and recommended today, what can happen when those aren't put into place is that, you know, really we can see this real significant potential or vulnerability for people to become -- to become stuck, where their identity and the identity of their community becomes wholly surrounding this experience, and not necessarily in ways that they feel or experience as being honouring of what happened, but rather, defining in a way that they might not actually choose or select.

So I'm -- I am forever struck by, you know, I think we can fool ourselves into this notion of thinking that, "Well, enough time will pass, and eventually I should be over it." I hear that story from individuals and organisations and communities all the time, "Well, it was 30 years ago, we should be past this now." But that's actually not what happens; right? No amount of time without the right factors and the right attention and the right support, no amount of time passing just spontaneously allows for the automatic recovery from these kinds of events. These kinds of events, as we're talking about, they change things permanently.

And as was said, this isn't about going back to how things were, this is about establishing how things are going to be in the face of and with the understanding that people and families and communities will be forever changed by this; however, it doesn't have to be a change that necessarily the only definition of which

is around the tragedy and the loss. It can actually, ultimately become a tremendously horrible tragedy that did allow a community to grow and define itself in the ways in which they came together.

So I see this at levels of individuals; I see this in couples, in marriages, you know, if a child has been lost; I see this in organisations when organisations lose members by suicide or if there has been a violence within an organisation, we had a -- there's an organisation I work with here in Calgary, who recently had a murder within their organisation; we see this at the level of communities that have experienced these kinds of mass casualties or mass traumatic events. If we don't find ways for people to honour and recognise and have ways to engage in within themselves and with each other, the working through and the messiness that that requires, the ways in which that will, and you know, understandably bring people to their knees, but that there's a -- there can be potentially another side to that.

If my -- my fear and my worry is for many communities and many communities I've worked with is that if we don't find ways to support that, over the long-term and in all the ways that are being described today, the potential for this to be the only identity in a very limited and limiting story is that much higher.

DR. EMMA CUNLIFFE: Thank you.

Jaclyn, one of the mechanisms that you've described in your report for assisting communities in the -- in the medium to long-term after a mass casualty is the innovation which is often known as resilience centres. I wonder if you can talk a little bit about what resilience centres do and why they're an effective mechanism?

DR. JACLYN SCHILDKRAUT: So we've sort of touched a little bit upon family assistance centres which emerge almost in the immediate aftermath to ensure a centralised location where individuals who are affected can come for information, sort of like a clearing house of resources if you will. And as I believe Lev might have said, and I apologise if it wasn't you, you know, those eventually leave and the Red Cross takes their, or maybe it was Mary, I'm sorry, takes their list of names and

goes, and then you have to figure out sort of how do we support the community and create that -- help to rebuild that sense of community or at least offer it a place, a centralised location where it can take -- where it can occur.

And so the resiliency centre that, from where I've seen it used in mass shootings, the first one was in Aurora, Colorado, which had a movie theatre shooting, actually 10 years ago next month, and it -- I actually was able to go out there and spend some time, meet the people who worked there, learn more about their services, and it's a centralised almost like a wellness location in the middle of the community where they offer a variety of different services. Because I think one thing that we've all touched upon in our own respective comments is nobody -- no two people are going to grieve this the same way and no two people are going to need the same services.

And so you have a range of opportunities that are available that can meet the needs of the people who are receiving the assistance where it can serve as a clearing house of information still in the ongoing, but also, help to build wellness and resiliency. And again, there's challenges that go into that, from funding to who that money can be used for.

In the United States -- so for my report to the Commission, I actually interviewed two directors of resiliency centres, and one of the challenges both of them articulated to me is that the funding that comes from our federal government can only be used for a very narrow group of individuals, so they then have to find other funding streams to be able to provide services to everybody who's affected. Then you run into timelines, which our government timetable doesn't move very fast, so you have to have seed funding to get your resiliency centre off the ground.

But then it also comes down to what does the community need. So in these two communities that have these resiliency centres, one director expressed to me how the community viewed it as, I don't want to say an albatross, but a constant reminder of their tragedy at a time where they were trying to figure out how to move

forward, and so they wanted the resiliency centre closed. Whereas this other community said, "No, this is our central place, this is what's brining us all back together, and we want it to stay."

Both of those communities, interestingly, have ongoing challenges related to their respective cases, but what also they have talked about is the different types of services and the way that you communicate it to people. So in actually our community, and I spoke with our director, and our community has a very big aversion to things called "therapy" so they brand everything as "wellness". And so even though you're still engaging in therapeutic practices, you're doing it from a place of wellness that has increased by and in participation because you're meeting people where they need to be.

I will say, you know, they have talked about a number of different services, and they do things from, you know, Yoga, and mindfulness and wellness, to art therapy, to equine therapy, group sessions, individual sessions, again, making sure that there is stuff available to everyone, but it's not just enough to build a resiliency centre, you have to make sure that people know about it.

And so in our community, the members of the team that established it, which it was built with the -- a service-based provider already existing in the community that had a lot of ties, is they would go to farmer's markets, and they would go to places of worship, and they would go where the people were and talk to them and say, "Here's how we can help you. We're here to listen to what your needs are."

And so again, we've talked a lot today about creating spaces for people's voices to be heard and resiliency centres are a great way to be able to do that.

Thank you.

DR. EMMA CUNLIFFE: Thank you.

I'm going to shift gears a little bit now and have a bit of a conversation about a modality that's sometimes called peer-to-peer support, but it's a particular word for a bigger idea, which is communities who have experienced similar

events taking care of one another.

Mary, I wonder if I could begin with you, please? I know that peer-to-peer support is an important methodology that VOICES utilizes. And you described a little bit of -- some of how you bring groups together in an earlier answer.

What have you seen the value of peer-to-peer supporters being? How has it helped?

MS. MARY FETCHET: Well we've held over 2,300, that's what we've documented anyway, support groups over the years. And what we're seeing, you know, I think to Jaclyn's point, resiliency centres play a role, but both after 9/11 and after many of these tragedies, now the organization goes away.

What we're seeing with the individuals that we're working with, and it goes back to the thought about people want you to be over it, move on, you know, isn't it 10 years? In our case, over 20 years since the tragedy. So both the support that they receive or don't from their family, and friends, and colleagues, may disappear because that person wants them to get back on their feet, to return to who they were prior to their loss, and to move on, and that just can't happen.

So I think what the peer support group provides is an opportunity for individuals to come together that have a shared loss, a shared experience, and are able to talk freely among each other.

And the word validation was brought up. Validation is big time. And I know we had a surge of survivors, I mentioned there were about 500,000 people that survived the attacks, 90,000 responders. And of those individuals, there's over 83,000 now in treatment for one or more medical conditions. But they also have -- depression, anxiety, and PTSD are in the top 10 certified conditions that they have.

So, you know, different than, but complimentary to the psychological treatment that they might have, some individuals that have started our groups this year have said that the peer support group was more helpful than 17 years of therapy.

And I think it all comes down to the validation, validated talk with people that understand, rather than having to educate, oftentimes, if you can imagine, needing therapy 20 years later, where do you start about where your experiences with a mental health provider?

So we do peer groups, but also support groups that are led by a clinician.

One other thing that was brought up was, and I feel very strongly about it, is the psychoeducation and not pathologizing the experience or the condition that these people have, being in a place where you're educating them about the many issues that impact them, or the many conditions that exist as a result of going through a loss. Certainly bereavement, trauma, any of the medical conditions that may be -- you know, they may be prone to.

But also about resilience. How do you take the loss of a loved one, or witnessing, or responding to the unimaginable? And how do you provide that person with skills to really understand what are their strengths and how can they build on those strengths to become more resilient?

Certainly the community, a supportive community, is, you know, an important component to that.

DR. EMMA CUNLIFFE: Thank you, Mary.

And in our conversations before the roundtable, you kindly indicated that some of the programming that VOICES offers is available to members of the communities affected by the mass casualty that this Commission is tasked with understanding.

I wonder if you could please speak briefly to that?

MS. MARY FETCHET: Well we hold monthly psychoeducational programs. Right now we're doing a three-part series in cooperation with the National Centre for PTSD. We do a lot of awareness campaigns. June is PTSD awareness, so we're doing a three-part series on that.

And we have authors participate that have written books on relevant topics.

We also have conferences. And we have a conference coming up on September 9th and 10th in New York City that will be in person, but also broadcast live.

So any of the events that we have right now are, you know, in addition to being in person, are online. And certainly people can go to our website, which is VOICESCenter.org, and register, and we'll be happy to add you to our distribution list.

DR. EMMA CUNLIFFE: Thank you very much.

Jaclyn, your report refers to the Rebels Project, which is another model of peer-to-peer support that I know you're keen to speak to a little bit. And I wonder if you could share a bit more information about the Rebels Project and how it works?

DR. JACLYN SCHILDKRAUT: Yes, thank you.

I just want to echo many of the statements that Mary made, because, you know, certainly she speaks from a much more knowledgeable place than I do. But you cannot underscore enough how important it is for somebody to validate how you're feeling, not because they're trained to validate your feelings, but because they actually understand what you went through.

And I say that, you know, obviously listening to survivors, but in my own experiences as somebody who, through my work, has experienced vicarious trauma that nobody around me seems to understand, except my friends who are mass shooting survivors.

The Rebels Project is an organization that began 10 years ago after the shooting at the movie theatre in Aurora. And it was started by a handful of no longer students, but they were students at the time. They had survived Columbine.

And in our country, and perhaps worldwide, most people see

Columbine as sort of this first moment because we saw it unfold on T.V. in a very different way than we had others, even though there was numerous other shootings in our country that happened before Columbine.

And part of the trouble, I think back then, and somebody mentioned it earlier, that we know now more -- we now know more today than we did 20/23 years ago.

And so these individuals who survived their very worst day saw this happen in a community 35 minutes away from them and said, “How can we help? How can we take everything that we’ve learned now 13 years later from our tragedy, and how can we use that to help others?”

And so in this sort of informal conversation, they created this group called The Rebels Project, which began, at the time, in 2012, with about 100 members of people who were impacted by various tragedies, mostly mass shootings, but there are some individuals who have survived bombings, there’s some 9/11 survivors in there.

And through just their outreach, and connecting with others who have been affected as well, they, today, now are more than 1,400 members strong from over 120 different impacted communities.

And so what I was able to do, in my initial article that led to my work with this Commission, is interview survivors.

And to Mary’s point, peer-to-peer support cannot replace traditional counselling, but it definitely compliments it, because they’re able to say to individuals, “We understand where you’ve been, and we can even tell you 18, 19, 20 years later, here’s what our journey looked like, and yours might look different, but here’s some holes you might need to navigate or work around. And it has numerous benefits; it has benefits for the receiver who understands that their experience is normal for what they are dealing with. It helps to provide them outlets of support where they can talk to other people.

And, also, it honestly benefits the giver as well because so many

individuals who experience these tragedies want to help and want to know how they can take what they've endured and turn something positive from something so negative. And that's where that peer-to-peer support has been so helpful.

What I think is also very important to acknowledge is that we've talked about different layers of impact, and even that comes into play with peer-to-peer support network.

So to give you an example, in my first -- in my initial research with Columbine survivors, I had parents who lost their children that day talk about their need to connect with the other parents and families that lost children that day, and then I had students who were in the school, in different parts of the school, who felt safer and more connected to the people who had experienced it in the exact same way that they had. So even though they were all touched by the same tragedy, they all connected differently based on how they were affected by that tragedy.

One of the benefits of The Rebels Project is it does exist largely online; they have Facebook groups and other mechanisms where survivors can go on. It's very carefully vetted to ensure that outsiders are not coming in and infringing upon their space. And you can connect with individuals who have experienced similar tragedies, who have been affected the same way.

But, certainly, the virtual network, especially over the last two and a half years dealing with COVID, has been incredibly valuable, but they also augment that with in-person gatherings; members of their group travel to affected communities to meet with families and individuals who have been affected. So there's many different ways in which those connections can be fostered, but the most important thing is understanding that those connections are incredibly invaluable.

DR. EMMA CUNLIFFE: Thank you.

Serena, this is an important conversation, I think, about -- we've heard a lot about the strengths and the -- that are present in communities, if you look for it and if you build it.

I'm interested, if you're able to share with us, what are some of the ways in which your community has taken care of one another since the mass casualty took place?

MS. SERENA LEWIS: I think it's important to recognize that I come from one small community of many rural communities that have been impacted by this. So in no way do I want to speak on behalf of all of the families and all of the communities. That just feels really important to acknowledge.

What I have witnessed, as I have witnessed, probably what you're saying, Jaclyn, some solidarity with certain groups, certain area volunteer firefighters, in some instances, have been able to come together, supporting, attending, being part of this. I see some groups getting together now, starting to look at park spaces and building renovation spaces.

So, again, I think it comes back to some of those different styles of the way we grieve. So our instrumental grievers are busy doing some of those things that are important to them. And, again, those intuitive grievers that we often see who are feeling this in a different way right now, and maybe more quietly.

I'm not sure exactly, Emma, how to speak to that. I still recognize that we have amazing resources in this province and in the affected communities, but I applaud each of you that you're acknowledging that this is very early on. And what I do see is a tremendous amount of weariness, especially from our frontline people who are trying really hard to keep this up, from the communities of schools, hospitals, long-term care, our businesses. So I think we're trying to navigate this, maybe, in the best way that we can right now.

We know that that collective response is important. Our voices are incredibly important in this, but likewise, we need the research and the people that have the longitudinal viewpoint of this, that are going to help us recognize the interjecting points of getting things in place.

We have certainly made recommendations to ask for a centre as

well that, again, is inclusive, diverse. We have amazing programs in our purview around horticulture and art and all of the different ways of greenspace and nature and those kinds of things.

So they are attainable, accessible. We know this from research. We've put these recommendations forward as an important part of possibly moving forward. We know that that isn't going to be for everybody, but we also recognize that -- and I applaud the person who said the messiness of this -- Megan, I think that was you, and I think right now from my own perspective, which is very personal, I do see a tremendous amount of messiness to this right now, so I think we're trying to navigate that.

DR. EMMA CUNLIFFE: Thank you for that very thoughtful answer.

So conscious of time, I'm now going to move to an invitation to each of you to respond briefly to the next question, which is really is there anything that you came to share today that you'd like the Commissioners or Participants to understand that you haven't yet had an opportunity to speak to?

And, Grete, if I may begin with you, please?

DR. GRETE DYB: I think my message would be that you really take it seriously; that it will take time, and that you put -- you get the resources you need to get this going and then the people know where to get help, and that they are contacted proactively and asked what are their -- what is their struggle, so that they can get adequate help.

We had to do that again almost 10 years after because we realized that 30 percent of our sample still needed help that they didn't have at that time. And many of them had used their helpers; they were not helping them anymore. So they needed new helpers. So we had one person in the region, in each region, that contacted them and, you know, kind of tried to investigate what they needed and tried to get them that help.

Some need just a lawyer to help them with all the mess that is

around them; some need more financial support because they're not well off. And some need psychological, medical help. It's not all health services that they need, there are also other things. But that has been tremendously helpful, even though it's been so long, so many years after the event.

So I hope -- we got that help established due to that one of our Ministers had done something really stupid, so the Prime Minister stepped up and say, "What you need?" And we jumped to it, and said, "We need three things. We need research, we needed victim support group have their financial help, and that we need these persons to investigate what directly exposed, at least, need now and get that established."

DR. EMMA CUNLIFFE: Thank you.

Megan, if I may turn to you next, is there anything else that you'd like to share today?

DR. MEGAN McELHERAN: Yeah, thank you.

Again, thank you so much for letting me be here and the opportunity to participate. This has been a really meaningful conversation; I hope it's been helpful.

I think there's two parts I would just like to finish with. I think the main thing I want to say is probably just a reiteration, which is for the community members and family members, the permission to just allow yourselves to be where you are; that I am in bewildered awe often by how loss and trauma and tragedy, like we've been talking about today, can really bring people and communities to their knees. And at the same time, the incredible capacity I have witnessed in people to reclaim their lives from this kind of event.

And I suppose -- so to me there's a bit of a "both, and," and right now the one side of this is -- this is still early days and there's rawness, and messiness, and pain, as we've been talking about. And there's a place for hope. There is an opportunity for growth to come from this.

And, you know, I was struck when Jaclyn was talking. You know, even when we start to see that inclination for people to want to be available to others who have been through this type of experience, that's what we would be looking at when we think about things like post-traumatic growth.

So I suppose that's message one.

The other message, and I don't want to go too much on this point, but I actually wanted to just mention, if you weren't aware, the Federal Government just yesterday announced just shy of $30 million in funding for front-line workers who have been impacted from a mental health perspective through the pandemic and beyond. And so my hunch would be there would be lots of community members maybe here today who could avail themselves of this support and would be very happy to provide any of that information to the Commission, if that would be of interest.

So just thank you again for letting me participate. And again, my condolences to all for the losses that have occurred.

DR. EMMA CUNLIFFE: Thank you very much indeed.

Levent, if I can turn to you?

MR. LEVENT ALTAN: Thank you.

I certainly echo Megan's last words and I think the points were at is particularly important.

I think one thing to always bear in mind in these situations is many people want to do many things and it's somewhat chaotic. And having frameworks and structure around all of that, and a strategic Commission can really help because you can have lots of people going in different directions and it's helpful to come together as a community and work out what that vision is and how you can best do that, understanding that there are multiple solutions, but you need to coordinate together, and that's effective, not least because of the efficient use of limited resources. So I think that's particularly important.

Understanding it's everyone's role, and we say this about support

and the framework you see behind me, in the sense of this is a national victim support framework that we've put together and there are many ways in which people experience victimization, different kinds of victimization and trauma, and many of the solutions and approaches that we're talking about with respect to mass casualty are in many ways applicable in other situations.

So understanding what everyone's role is and empowering them to be supportive within the community and with individuals is really critical. And that's coming back to one of Megan's points about worth and the community doesn't have to be defined by -- they shouldn't be defined solely by what's happened there.

Many of the solutions to resolving and growing are also solutions for community, community cohesion, community principles, and the entire fulfilment of that -- of the individual community.

And so seeing these things in that broader perspective is important because you understand then that this isn't simply about answering a singular incident. It's about answering the question, "How can we, as communities, thrive?" And I think that's essential, particularly when we're facing many different kinds of unstable situations, high levels of migration, climate change, new technologies and where we're going, and the kinds of solutions that we've been talking about strengthen us to cope with all of those issues.

So I think it's important to understand that within the context of what we're trying to do within this instance.

DR. EMMA CUNLIFFE: Thank you.

Mary, if I may turn to you?

MS. MARY FETCHET: Well, I'll start -- end where I began, and that's to offer my condolences to the families and just encourage them -- you know, to garner the support that they need and to be around positive people that are going to really help you heal. And don't forget about how important it is to commemorate the life of the person that you lost. Remember, and maybe you don't feel that way right now,

but you will come to a time where you can talk about them. And I'm going to cry now. And -- but to keep their memory alive in whatever way that you see fit.

And then, of course, to think beyond the families to the broader community. I know the survivors that we work with, you know, from the day onward, people say, "You're so lucky you survived the attack," and they don't feel lucky. They saw things they should never have seen. They didn't have the support because people thought they were lucky. And they do need support and validation that what they saw and experienced, sometimes life-threatening experiences, are really life changing for them.

And, you know, over the course of time, when you think in terms of 9/11, it's 20 years, we have some survivors that have never talked to another survivor before. In 20 years. And so I think to build that understanding that although they're lucky, they still need support.

And then, of course, people like Serena, that are in the trenches, you know, trying to support the community. The responders have needs too. And, you know, it's not easy.

You know, after many of these tragedies, you know, even security is an issue. You have, you know, in our case, the president coming in to Newtown that has one road in and one road out. You know, at the same time, funerals that are going on.

And so -- and then lastly, just to say that, you know, of course I think I speak for everyone on the panel, that we're here to support you. So anything that you may need, you know, whether it's the families, the people that survived, or Serena and the people that she's working with, we're here to help. And we've learned a lot, unfortunately. But you have to go through it. I mean, there's no way around grief. You have to move through it and have the support that you need, and be around positive people that are going to support your healing.

DR. EMMA CUNLIFFE: Thank you.

Terry, if I may turn to you?

DR. TERRY MITCHELL: Thank you.

I want to say, Mary, thank you for sharing in your very personal way. Thank you.

I want to go back to the community psychologists and the clinical psychologists are, like, looking for space, what I want to say, within need.

But I want to say, from a community health promotion and community wellness theory and practice, that to build -- from a health promotion wellness perspective, to build creative supportive environments, to strengthen community action with the community, and to reorient health services.

And what I mean to say, reorientate health services that -- with the community, that the Province would figure this out, but there has been an exceptional event. There's no arguing that there's an exceptional event, a national crisis, a provincial crisis, family, individual crisis. An exceptional event that has been exceptional. We're talking about our exceptional traumatic responses. And therefore, there is an executional need. An exceptional need for appropriate government support for appropriate and accessible healthcare in all of that definition.

But right now, as I also live in the Maritimes, I know that accessible health care is really out of reach.

But I want to say, for this community, from my personal and professional position, is this is an exceptional event, an exceptionally traumatic response, and therefore there's an exceptional need for an exceptional response from government.

Thank you.

DR. EMMA CUNLIFFE: Thank you.

Jaclyn?

DR. JACLYN SCHILDKRAUT: To everybody that is here and that is watching from home and may watch this later, thank you. Thank you for welcoming

us to your community, to your tragedy, and allowing us the space to try and help in any way that we can.

Thank you, Commissioners, for having us here. I'd just like my final remarks to be to those who are affected, if that's all right.

You shouldn't need permission from any of us to feel the way that you feel, to be impacted the way that you are because you didn't have a choice in any of this, and so I would encourage you to give yourself that permission to feel and to grieve however you need to grieve and to process your tragedy however you need to process it, and to understand that it's no timetable, and not to let anybody, not resources, not your peers, no one, no one gets to tell you on what timetable this happens.

Every single person who was affected by this tragedy in any way, shape or form, your experiences are valid, they are important, and they deserve to be addressed. And so I just want to let you know that, as Mary so eloquently said, we are all going to be here long after today to support you in any way that we can. So please know that no matter what you are never alone. Thank you.

DR. EMMA CUNLIFFE: Thank you, Jaclyn.

Serena, the last word goes to you.

MS. SERENA LEWIS: Thank you for that, Emma, and to each of you.

Since April 18th and 19th, I have tried to function in my life with two words, and they are "truth" and "grace", and I believe throughout this process we need truth, we need facts and we need understanding, but they can only be delivered with the element of grace and humility for the devastation that this has caused.

I believe that our physical safety has been completely disrupted in these communities. I also think our psychological safety has also been disrupted. This is an identity that we're all struggling with at this time. I want it to be an identity that we can recreate.

I have two sons. I know that trauma begets trauma. I want

different for our children in these communities. I want different for our seniors in these communities, and for all of the colleagues out there who have been serving in incredible ways.

This is Canada's largest mass casualty event that has occurred in a series of rural communities. I impress upon the Commissioners and all of the people present through this process that you are part of helping us get up on our knees again. And being communities that will be aligned with communities like this, that we will be able to tell our stories in ways that we're progressing in research and knowledge and capacity, building in ways that Canada has never really had to look at this intensely yet.

I want our approaches here to be integrative, recognising our historical trauma as well, and knowing that this is cumulating for all of us across this province in so many ways. So if anything can come out of this crisis, please help us make it an opportunity for growth, not only for my kids, but for everybody else's as well.

Thank you for the invitation to be part of this today. I can't tell you how meaningful this is, but also how hard it's been.

DR. EMMA CUNLIFFE: Serena, thank you.

Commissioners.

COMMISSIONER MacDONALD: Commissioner Fitch?

COMMISSIONER FITCH: Thank you. Just a note to say that I made a lot of comments in my book today, mostly focussed on recommendations from the very wise input from all of you. It's greatly appreciated. Like many other panels, I wish that we had a week to sit around and continue this dialogue.

Thank you, Commissioner MacDonald.

COMMISSIONER MacDONALD: Commissioner Stanton?

COMMISSIONER STANTON: It's been such a helpful discussion in so many ways, and one of the things that strikes me, as I -- and Dr. Dyb, you touched upon it—and I'm -- I mean, all of you bring experiences with you to this work and the care that you bring to the work—here, you are late in the evening in your country

following very closely on the heels of a mass casualty, and we've all been thinking about our colleagues in Norway during this time, so I appreciate you being here.

But you talked about how you became involved in the work in the first place because you were asked to help after the Utøya mass casualty, and you looked around for resources and there really weren't any, and so you decided to create them. And that generative process, as hard as it is, and all of you who research in this area are necessarily doing work in the midst of tremendous pain and suffering, and it's -- Dr. Schildkraut, you talked about vicarious trauma as well. And one of the things that really strikes me about the -- people we've heard from in this process all the way through is the need to support the people who support. So all of the people who do the work to try to assist the other people doing the hard work of grieving is a piece that I think is important to attend to as well.

And so I just wanted to express my appreciation to all of you for doing what some people might see as sort of this removed research, but that actually is coming from a place that is very caring. So I just wanted to acknowledge that and appreciate it. Thank you.

COMMISSIONER MacDONALD: Thank you so much.

And it falls to me to thank you as well, beginning by thanking you, Emma, for not just a wonderful job facilitating this very important panel, but for organising it, and of course for Nichole Elizabeth as well, as you've indicated. So we're very grateful.

To our panelists, I have seen a lot of kindness and generosity here today, and it visits us in two aspects: One is helping us with this very important aspect of our mandate, so directly helping us and being here for us today; but kindness and generosity on another front, and that is to the survivors. I was struck by your kindness to the survivors as the suffering continues to cascade and reverberate from its painful core outward.

So we've had the benefit of your collective, a tremendous

combination, actually, of expertise, direct experience, and Mary, I look to you with gratitude, and with your wisdom, it seemed to have gelled for me and I'm sure for everyone in a -- in a very wonderful way. You delivered your messages with conviction, candour and sincerity, and we really appreciate that.

If I could be so bold as to use first names, to Grete and Levent, Mary and Meghan and Serena and Terry and Jaclyn, collectively you've given us a gift for which we're very grateful here today, so thank you all very much.

And we have some administrative matters to deal with, so you are, of course, free to go, and again, thank you to everyone.

DR. TERRY MITCHELL: Thank you for the opportunities.

--- Upon recessing at 1:06 p.m.

--- Upon resuming at 1:10 p.m.

COMMISSIONER MacDONALD: And thank you so much for our technical crew and their amazing agility.

Mr. VanWart?

MR. JAMIE VanWART: Yes. Thank you, Commissioners, and certainly thank you to the staff for facilitating this more administrative moment.

At this time, I'd like to move to tender six documents as exhibits. These are documents that have been shared with Participants. They relate to a meeting that was held on April 28th, 2020, involving senior members of the RCMP.

We know there has been some significant attention paid to these events surrounding the meeting. In our view, it is in the public interest to file today as exhibits the relevant documents that the Commission currently has identified in our process in order to share this information with the public in a timely and transparent manner. I should note that these are documents that was anticipated to be filed as exhibits in any event later in proceedings this summer when we hear from additional senior members of the RCMP.

So Madam Registrar, I move to tender the following documents.

The first is COMM0059349. This is an email dated April 28th, 2020, sent to all of the RCMP H-Division staff from the Assistant Commissioner Lee Bergerman, with the following subject line: "Sharing Commissioners Message".

REGISTRAR DARLENE SUTHERLAND: That's Exhibit 2642.

MR. JAMIE VanWART: Thank you.

--- EXHIBIT NO. 2642:

(COMM0059349) - Email dated April 28th, 2020, sent to all of the RCMP H-Division staff from the Assistant Commissioner Lee Bergerman, with the following subject line: "Sharing Commissioners Message"

MR. JAMIE VanWART: And the next COMM number is COMM005 or 0035773, and this is the attached letter, dated April 27, 2020, from Commissioner Lucki to H-Division.

REGISTRAR DARLENE SUTHERLAND: Its Exhibit 2644.

--- EXHIBIT NO. 2644:

(COMM0035773) - Attached letter to the email dated April 28th, 2020 from Assistant Commissioner Lee Bergerman, dated April 27, 2020, from Commissioner Lucki to H-Division

MR. JAMIE VanWART: Next, is COMM No. 0051407, and this is the notes of Chief Superintendent Chris Leather, dated April 21st, 2020 to April 31st, 2020.

REGISTRAR DARLENE SUTHERLAND: Two-six-four-five (2645).

--- EXHIBIT NO. 2645:

(COMM0051407) - Notes of Chief Superintendent Chris Leather, dated April 21st, 2020 to April 31st, 2020

MR. JAMIE VanWART: The next is COMM No. 0058639, which is the notes of Assistant Commissioner Lee Bergerman, dated April 19, 2020 to October 27, 2020.

REGISTRAR DARLENE SUTHERLAND: Exhibit 2646.

--- EXHIBIT NO. 2646:

(COMM0058639) - Notes of Assistant Commissioner Lee Bergerman, dated April 19, 2020 to October 27, 2020

MR. JAMIE VanWART: Next is COMM No. 0059353. This is an email dated April 14, 2021, to Commissioner Lucki from Lia Scanlan, with the following subject line, quote: "Letter Regarding H-Strong Meeting - April 28, 2020.

REGISTRAR DARLENE SUTHERLAND: It's Exhibit 2647.

--- EXHIBIT NO. 2647:

(COMM0059353) - Email dated April 14, 2021, to Commissioner Lucki from Lia Scanlan, with subject line: "Letter Regarding H-Strong Meeting - April 28, 2020

MR. JAMIE VanWART: And finally, COMM No. 0059354, which is the letter attached to this email, which is a letter to Commissioner Lucki, authored by Lia Scanlan.

REGISTRAR DARLENE SUTHERLAND: Exhibit 2648.

--- EXHIBIT NO. 2648:

(COMM0059354) - letter attached to the email dated April 14, 2021, to Commissioner Lucki, authored by Lia Scanlan

MR. JAMIE VanWART: Thank you, Commissioners. Those are all the exhibits.

COMMISSIONER STANTON: Thank you, Mr. VanWart.

And thanks again to the roundtable members for assisting us with our work in helping to consider lessons learned and recommendations to strengthen community safety. And of course, our Orders in Council direct us to examine the information and support provided to the families affected, citizens, police personnel and the community, and so the roundtable is connected to that part of our mandate.

If the roundtable prompted you to think of research that could be

relevant to our work, or an idea to make your community safer, please do share it with us through the public submissions survey on the website.

There will be no public proceedings tomorrow. We'll return on Thursday at 9:30 a.m.

Thanks, everyone, and we'll see you then.

REGISTRAR DARLENE SUTHERLAND: Thank you. The proceedings are adjourned until June the 30th, 2022, at 9:30 a.m.

--- Upon adjourning at 1:15 p.m.

C E R T I F I C A T I O N

I, Sandrine Marineau-Lupien, a certified court reporter, hereby certify the foregoing pages to be an accurate transcription of my notes/records to the best of my skill and ability, and I so swear.

Je, Sandrine Marineau-Lupien, une sténographe officiel, certifie que les pages ci-hautes sont une transcription conforme de mes notes/enregistrements au meilleur de mes capacités, et je le jure.

Sandrine Marineau-Lupien