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
CommissionDesPertesMassives.ca

Public Hearing

Audience publique

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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Appearances / Comparutions

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Mr. Joshua Bryson	Counsel / Conseiller
Ms. Tara Miller	Counsel / Conseillère
Ms. Tara Long	Counsel / Conseillère
Ms. Linda Hupman	Counsel / Conseillère

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Truro, Nova Scotia

--- Upon commencing on Tuesday, September 20th, 2022, at 9:33 a.m.

MS. DARLENE SUTHERLAND: Good morning. The proceedings of the Mass Casualty Commission are now in session with Commissioner Michael MacDonald, Commissioner Leanne Fitch, and Commissioner Kim Stanton presiding.

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, including those here in Nova Scotia, across Canada, and in the United States, and all others affected by the April 2020 mass casualty in Nova Scotia.

Today we begin our final week of public proceedings. Throughout this week, we'll be hearing final oral submissions from participants.

As you know, the participants have been an integral part of this inquiry from the very early stages in our process, providing feedback on the foundational documents, helping to identify material gaps, helping identify and question witnesses, contributing to roundtable and discussions, and providing regular oral and written submissions.

We appreciate their commitment and look forward to hearing more of their perspectives on recommendations this week.

Today, we will begin hearing from three different participant counsel representing family members and those most affected. Michael Scott will start, follow, and start, and followed by Josh Bryson, and then Tara Miller. We will end the day with self-represented submissions from Tara Long.

And I think I need to make a correction there. I believe it's Ms. McCulloch, perhaps, who is starting. Sorry.

So Ms. McCulloch, if you would please start us off with submissions

from your client.

--- SUBMISSIONS BY MS. SANDRA McCULLOCH:

MS. SANDRA McCULLOCH: Good morning, Commissioners.

My name is Sandra McCulloch. I'm here with the firm of Patterson Law, and as you know, we represent a majority of those identified as having participant status as those most affected before this Commission.

Commissioners, I want to take a moment to identify specifically whose interests we advocate for during this public inquiry.

Firstly, we represent the families of Greg Blair and Jamie Blair. Greg and Jamie were the apparent first to lose their lives to the perpetrator at approximately 10:00 p.m. on April 18, 2020. Their deaths were confirmed by the RCMP when the RCMP first arrived at the Blair house in or around 5:21 a.m. on April 19th, more than 7 hours after Jamie called 9-1-1 and was shot by the perpetrator while she protected her and Greg's young children, who managed to survive and flee to seek help.

But there is emphasizing, Commissioners, information that Jamie conveyed about the "police car" that was "labelled RCMP" during her 9-1-1 call.

Our firm represents the family of Lisa McCully. Lisa encountered the perpetrator at some point after emerging from her home, potentially between 10:13 and 10:16 p.m., while her young children remained in the home, to be joined by Jamie and Greg's children.

Not knowing the extent of Jamie, Greg, or Lisa's fates the children had to shelter inside Lisa's home, exhibiting extraordinary calm and clarity while they assisted first responders during the more than two hours that they waited to be rescued.

We represent the families of Frank Gulenchyn and Dawn Madsen. Frank and Dawn's encounter with the perpetrator appears to have happened shortly before 10:25 p.m. when Andrew and Kate MacDonald saw fire at Frank and Dawn's home, and a "police officer" in their driveway identified by them during their phone call to 9-1-1 seeking help.

We don’t know exactly what happened to Frank and Dawn, but we know that only minutes after, the perpetrator was driving away down Portapique Beach Road past the area where RCMP members were arriving in the community in response to Jamie's 9-1-1 call.

Our firm represents the families of John Zahl and Joanne Thomas. We do not know exactly what happened to John and Joanne either, but we know that they lost their lives and were in their home, which the perpetrator set ablaze.

One thing we do know, however, is that as late as 10:26 p.m., Joanne was known to be communicating with friends via text message, and there is no indication that she or John were in any apparent distress at that time.

We also represent the family of Corrie Ellison. Corrie was visiting his father, Portapique resident Richard Ellison. Corrie appears to have been shot by the perpetrator at or around 10:40 p.m. while he was on Orchard Beach Road observing the fire as the perpetrator apparently moved through the community, again, past Jamie and Greg's home and Lisa's home toward his exit.

I pause for a moment to stress that the story of what unfolded in Portapique in April of 2020 is not complete without the acknowledgement of the loss of lives of fellow Portapique residents Aaron Tuck, Jolene Oliver, Emily Tuck, Peter Bond, and Joy Bond, whose counsel are here to speak on their behalf.

The story that the Commission must fully consider also is not complete without consideration of those left behind in Portapique, those who survived the mass casualty event, a number of whom are also represented by our firm.

We represent Clinton Ellison. He's the brother to Corrie and son to Richard. Like Corrie, Clinton was also unknowingly walking into danger as he went to search for Corrie along Orchard Beach Road prior to finding Corrie, walking that same stretch of road that the perpetrator travelled in within moments of one another, only to have to flee for his own life at the sight of an unidentified flashlight.

Our firm also represents Mallory Colpitts and Darren Murphy,

Darren being participant in this Commission on behalf of his late brother, Bernie Murphy.

Mallory and Bernie were residents of Portapique, two of several left uncontacted in the community overnight, unaware of the extraordinary violence committed by the perpetrator or any risk around them until the morning hours.

Our firm represents Leon Joudrey. He's another such resident. He resided near to Jamie and Greg's home and he was actually moving around in the community in the early morning hours, and he encountered the RCMP multiple times, but was told nothing of the risk to which he was exposed until early morning contact from the perpetrator's partner, Ms. Banfield.

Our firm also represents Debra Thibeault, another resident of Portapique, who similarly had no alert of the violence happening in the community. You'll recall that it was Ms. -- it was Debra's makeshift gate that the perpetrator drove through to escape Portapique by the east while the RCMP organized their initial containment efforts entirely to the west of Portapique Beach Road.

And of course, our firm represents Richard Ellison. Richard was left behind to hide in his home on Orchard Beach Drive overnight, knowing that there was a risk in the community, but not what, while awaiting information, any information about his sons, Corrie and Clinton.

Richard serves as an intense reminder of the violence that continued into the following day beginning in the early-morning hours at Hunter Road in Wentworth.

Commissioners, our firm represents the families of Sean McLeod and Alanna Jenkins. Sean and Alanna’s home was an apparent hideaway for the perpetrator to which he travelled undetected from Debert. We also don’t know exactly what happened to Sean and Alanna prior to the perpetrator setting fire to their home but I submit that it is important to acknowledge that we do know that in the early morning, Alanna was having cell-phone contact with a friend.

Our firm also represents the family of Thomas Bagley. During a morning walk, Tom appears to have approached Sean and Alanna's home. Tom was shot and killed by the perpetrator near the entrance to Sean and Alanna's home. And I just note that Tom's cell phone was on his person.

Unnoticed, the RCMP not having located the perpetrator or warned anyone that he was at large, the perpetrator then carried on through Wentworth and beyond, first claiming the life of Lillian Campbell, whose counsel you will hear from soon.

Our firm represents Carole Fisher and Adam Fisher. Their home was violated by the appearance of the perpetrator moments before 9:48 a.m. where he unsuccessfully tried to gain entrance. This appearance came after the perpetrator was sighted by Cpl. Peterson who radioed his sighting but drove away in the opposite direction for approximately 1.2 kilometres before turning around to try to find the perpetrator. We know that during the time it took for the RCMP to mobilize in response to Carole and Adam's 9-1-1 calls, including initially staging well away from Carole and Adam's driveway, the perpetrator was long gone and moving down Plains Road in Debert.

Our firm represents the family of Kristen Beaton and her unborn child. Kristen was actively watching her cell phones for updates about the risk that the perpetrator presented to the public when she was blindsided by the perpetrator's approach when he opportunistically pulled off Plains Road and took the lives of Kristen and her baby.

Our firm represents the family of Heather O'Brien. Like Kristen, Heather was aware of unfolding events, driving where she believed she was a safe distance from harm. Pulled over on Plains Road, she heard gunshots while speaking to a friend on the phone. And Heather, in her final moments, expressed relief to her friend of an approaching police officer only for her friend to bear witness by phone of the gunshots the perpetrator inflicted upon Heather.

It was after Heather's death at 10:17 a.m. that the RCMP finally advised the public of the perpetrator's masquerade via social media. Alert Ready, the public alerting system, was not used, nor was it ever used that day to warn the public. The perpetrator carried on from Plains Road unobserved and the chaos that followed well apart from the perpetrator's actual location. Events unfolded at the Onslow Belmont Fire Brigade in Onslow.

As I've mentioned, we represent Richard Ellison. We also represent Greg Muise and Darrell Currie, Chief and Deputy Chief of the Onslow Belmont Fire Brigade, and who assisted with setting up a comfort station, this comfort station for residents having to flee Portapique. All of Richard, Greg, and Darrell were inside of the fire hall when the premises, along with Cst. Gagnon and David Westlake were shot upon by Constables Brown and Melanson during their search for the perpetrator.

Finally, Commissioners, we represent the family of Joey Webber. After travelling through a number of communities without accurate warning of the perpetrator's whereabouts to the public, the perpetrator committed further violence at the Shubenacadie Cloverleaf. Joey was shot by the perpetrator after being forced into the perpetrator's mock cruiser where his body was left.

I acknowledge that the loss of life suffered at Shubenacadie included the deaths of Cst. Heidi Stevenson and Gina Goulet, both of whom have counsel to speak for them.

Commissioners, by way of a rudimentary roadmap -- I want to make clear, it's not my intention to speak to more granular recommendations today. We will be addressing those in our submissions to follow. We're here today more so to speak to the findings that our clients hope that you make and the recommendations naturally to flow from them.

I want to stress that my clients are not experts on how to fix what went wrong in and around April of 2020. They do, however, have expertise to help you

identify what went wrong so my clients use this opportunity to highlight what they submit are the critical takeaways from the evidence that we have heard during these proceedings, critical takeaways that they say must feature prominently in your final report in the form of findings and, more specific, recommendations. Some of these facts, you will have heard from me already, and I'm going to speak a little more about the RCMP response in my comments that follow.

Toward the end of my submissions, I want to touch upon some of the concerns that our clients have here today at the end of this process in the hope that you will carry them with you and use them to inform your consideration of the evidentiary record and the conclusions that you produce.

Again, you'll have noticed that within my introduction, I've scattered what our clients submit are critical facts relevant to their particular stories which speak to key themes, what happened, why, and how themes, which our clients submit are begging for this Commission's attention, themes which they submit this Commission cannot but identify as deficiencies in the RCMP, both its response in April of 2020 and it's organization more broadly, that must be rectified in the future, starting with issues apparent during the mass casualty event.

In our Phase I written submissions, which I know you will have read, we identified a great number of failings that our clients submit were present on part of the RCMP, not failing attributable to a lack of funding as I expect you're going to hear, but failings linked to the RCMP simply not being prepared for the challenge of the mass casualty event causing it to deploy an inadequate response with tragic consequences.

Lack of training is something that was apparent in the evidentiary records. Our clients decry the decision to send only a bare complement of members into Portapique in the early hours. They submit that that decision appears to have been rooted in the RCMP's fear of being ambushed or being involved in a blue-on-blue incident, which our clients submit is rooted in a lack of training and tools to mitigate

against those fears, training like familiarizing local members with the communities they service or training like completing IRIT exercises over longer periods of time and outside of a well-lit building, or training like prioritizing potential threats and addressing them more promptly, and example of which involved the diversion of resources away from Portapique into the community of Five Houses.

In regards to a lack of tools, we submit that we've heard evidence about a lack of tools like modern GPS equipment such as the TMR2 GPS option not activated on existing RCMP devices in April of 2020 and other available safety and location equipment options that members have talked to you about during their evidence.

Our clients continue to be left to wonder what could have been achieved if the RCMP had overcome even some of these barriers, whether the children might have been rescued sooner or even had accompaniment by an RCMP member while they waited for rescue or whether the outcome for any of the victims in Portapique could have been different.

We submit that there are a number of communication failures. Of course, communication -- this won't be the first time I mention that word here today but during the mass casualty event, there was a number of communication issues present within the RCMP. We submit that you've heard evidence of a disorganized command structure with orders coming from multiple sources, an example of that being Sgt. O'Brien, who was off duty executing commands from home after being told not to. And we've heard evidence from members that spoke to confusion about who was in command.

We submit that another example of communication failures relates to individual members, subordinate members, who appear to have been making critical decisions independent of command such as Cpl. Peterson's decision to unilaterally -- unilateral decision to opt to distance himself from the perpetrator before turning to pursue or Constables Brown and Melanson who independently opted to drive through

Onslow in a hunt for the perpetrator, somehow with any apparent knowledge of the Onslow Belmont Fire Brigade comfort station and their fellow members' supervision of it. And then, of course, there's the example of a most critical communication error, not effectively sharing community knowledge about the existence of "a road -- kind of a road that someone could out", to share Cst. Colford's words. These are just some of the internal failures in communication that we submit are evident on the evidentiary record.

We submit further that there are communication failures outside of the RCMP as well, the most egregious of this being the failure to provide accurate and a meaningful warning to those in and around Portapique, not the least of which is the extraordinary misrepresentation in the warning provided to the public which remained the ambiguous "firearms complaint" tweet until 8:02 in the morning on April 19th, 10 hours after Jamie and Greg were first shot.

We submit that another area of deficiency in the RCMP's response during the Mass Casualty event related to the handling of intelligence. We submit that the evidence supports an inordinate amount of ball dropping occurred in respect of intelligence gathering and handling. I've already shared one such example with you of it failing to ensure critical information about a possible exit out of Portapique, but there are others.

Another such example is the failure to catalogue and retain critical information coming in. It doesn't appear to our clients that from the whole of the evidence that there is any infrastructure around the command structure to filter or, where appropriate, re-filter information to identify gaps which were fillable.

Commissioners, we submit that it's incomprehensible that Andrew and Kate MacDonald were unknown to commanding members. The staff sergeant that assumed command hours after the event began, completely unaware of their interaction with the perpetrator.

We submit that another example of a failure of gathering and handling intelligence relates to the investigative measures which were not taken. These

include, as we have said before, a failure to follow up with the MacDonalds or with the children as to the information they could provide in a timely manner or at all.

But just as significant is the failure to not take the opportunity to learn anything possible from members of the community, to learn what they might be able to share to inform the RCMP about the situation and the risk at hand. Ironically, I'm talking about community members whom the RCMP could have simultaneously warned and potentially brought to safety, people like Bernie and Mallory, Leon or Richard. There was an opportunity for an exchange of valuable information that should have happened and didn't, to everyone's detriment.

I want to point out that these high profile examples are not the only occasions where there RCMP failed to heed information from the public during the Mass Casualty event. There are examples of communication failures throughout in our client's submissions, including more discreet examples such as the RCMP waiving off the citizen who tried to alert it that Joey's body was in the perpetrator's burning cruiser at the Shubenacadie cloverleaf.

Another inadequacy in the RCMP's response during the Mass Casualty event related to a failure to use resources or have resources available. We learned not only was air support unavailable, we learned that in fact the helicopter of the RCMP was more often than not off duty sick, and it doesn't appear to our clients that there was any protocol in place for what to do when air support was off duty sick, as we saw in Portapique a scramble to make calls and search for alternatives.

And we would identify that there was a host of problems with the eventual alternative that was secured from the Department of Natural Resources, including time of departure no FLIR capability, and its inability to access encrypted radio channels effectively.

Another technology related resources related to mapping. It's our client's submission that it is plain that superior mapping options were not utilized. We learned about accessibility issues from members like S/Sgt MacCallum. And we

learned about unfamiliarity of options from members like S/Sgt Carroll.

We submit that in addition to failing to use superior options at the outset, the apparent reversion to paper or hand drawn maps instead of reverting a superior tool like pictometry only perpetuated the RCMP's mediocre understanding of the area.

And in terms of technology, you will have heard our firm repeatedly make submissions about the poor choice to rely upon Twitter and the good will of social media users to spread the very inadequate messaging being distributed by the RCMP and the critical failure to either use or having any reasonable awareness of the tool that the RCMP failed to put in its toolbox, Alert Ready.

Beyond these technological resources and community resources, we submit that there is also evidence of the RCMP failing to take advantage of other emergency response resources. There's much that can be said in this area but I would submit to you significant pieces in today's summary.

Firstly, it was deeply troubling to hear from EHS individuals who were on the scene that they were uninformed about the full extent of what was happening, and may well have watched the perpetrator exit the area without any awareness to advise the RCMP of what they might have seen. That's the second point.

And I appreciate that these are not uncomplicated issues but it's deeply troubling that the Truro Police Service could have been informed of the perpetrator's easterly movement on April 19th, and potentially could have assisted with preventing the perpetrator from passing the town of Truro or at a minimum established an informed or effective watch. But the RCMP didn't engage the Truro Police Service.

It should not have escaped the Commission's notice that the RCMP appears -- it appears that they would not have even known that the perpetrator passed Truro and into Brookfield but for Cst. Dorrington's personal contacts.

As a final high level point about the inefficiency, the inadequacies of the police, the RCMP's response in Portapique, I've put under the heading of "Tunnel

vision." Our clients submit that it appears that the RCMP simply chose a most likely scenario based upon a disbelief of what the reality of the event was in spite of what eye witnesses were telling it. Key features of this tunnel vision included simply not believing that the perpetrator's vehicle could resemble their own cruisers in spite of that being exactly what they were told right from the get-go by Jamie.

Not making timely or any inquiries in some instances, of eye witnesses or community members who were obviously better positioned to know the truth about the perpetrator and the community.

Apparently making assumptions about noises around them being indicative of the perpetrator's presence in the community and the lack of popping or explosion sounds being suggestive that he was in the community and had taken his own life.

And Commissioners, we've heard suggestions that the RCMP were alive to all possibilities but we submit that that is contrasted with the evidence. There are discreet examples that call that suggestion into question such as Mallory's account of the ERT having told her to just drive herself out of the community when she demanded to be extracted safely. Or Leon who moved about in the community without any meaningful warning at all.

And perhaps the biggest example is the RCMP's failure to warn the public of the possibility of what was really going on, that a man had murdered many people, was not in custody, and could be "anywhere in the province" according to the 8:04 a.m. BOLO distributed internally.

From our client's perspective, Commissioners, these facts and other related facts in the evidentiary record make two things abundantly clear. One, our clients submit that the RCMP very clearly was not prepared for what happened in April of 2020. The organization had not readied itself and its members for such a large scale event, and we observed a widespread inability to think outside the box with tragic consequences.

Secondly, our clients submit that this overall failure in preparedness led to a host of basic mistakes, mistakes like not seeking information from those best positioned to have it; mistakes like not relaying information to one another effectively or at all; mistakes like failing to accurately and effectively warn the public, and other basic mistakes. These aren't mistakes to be hidden behind the lack of funding or by viewing the event as a whole and calling it 'unprecedented"; these are in our client's view basic mistakes which contributed to the unprecedented nature of the event.

Our clients submit that the evidentiary record is riddled with same kinds of inadequacies on part of the RCMP in particular both after and prior to the Mass Casualty event.

I'm going to start with after.

We submit on behalf of our clients that there were inadequacies present in a variety of ways while the RCMP handled the aftermath of the Mass Casualty event, starting with communication to the public. The Commission itself identified through the evidence it gathered and .the information -- through the information the Commission has gathered and compiled into its foundational documents that the information shared with the public was not timely or accurate.

We've heard evidence to make us wonder whether communication to the public was tainted by in-fighting, if not opportunistic motives and inappropriate interference by placing priority on reporting about issues with a political vent, the firearms rather than simply reporting what the public needed to know.

We also submit on behalf of our clients that the failure in communication present in the RCMP's after response is present in the refusal to acknowledge any shortcomings on the part of their response. Perhaps the most difficult example to swallow is contemplating what happened at the Onslow Belmont Fire Brigade which our clients submit can't possibly be considered textbook policing in any form of the word.

Another area of inadequacies present after the mass casualty event

relate to investigative matters. The examples I would provide are generally more discrete ones, including failing to collect evidence. As we know there were bullet casings left behind in Heather's car and Gina Goulet's home.

Another discrete example related to the causing unnecessary fear by contacting Joanne's family to inquire about the identity of a possible third set of remains when a more thorough investigation would reveal that there were only two.

Another investigative concern relates to the failure to remove Joey's remains from the mock cruiser before it was towed away into evidence.

All of this, all of these discrete examples cast doubt for our clients about the level of care and attention given to those families and to the investigation as a whole.

In relation to next of kind notifications, we recognize that not all families were dissatisfied with how they were treated but the evidence does bear some distressing stories, stories like waiting unnecessarily for confirmation of deaths that were all but certain, such as in the case of Patsy Bagley who sat just a short distance away from the officers; who were promptly informed of Tom's identity on scene awaiting unnecessarily; such as in the case of Nick Beaton who spent the day stonewalled in his search for information only to finally be told about Kristen's death a moment before an evening press conference.

We've heard stories about families who have faced confrontation from members who refused to share the loved one's identity when asked as was the experience of the O'Brien family or waiting more than – more than hours but days for anything approaching confirmation of their loved one's death. Such was the experience of Ryan Farrington and his brother John as they tried desperately to learn of what happened to Donna Frank. And I add as a sidebar, Ryan has shared his knowledge with you that a distant family member of Donna Frank, who's a member of the RCMP, he's aware was promptly informed.

And then of course we have at least one example of people waiting

for notifications that never came. I find it difficult to remind you that Cory's son, Connor, was never given a next of kin notification at all, Constable Bent seemingly inexplicably unaware of Connor's existence for months.

That brings me to the family liaison officer role. We submit that accountability here is twofold with Constable Bent appearing to be under-trained and overwhelmed in that task, and Constable Bent apparently having no oversight or intervention in relation to his tasking as he carried it out.

There are numerous examples of our clients feeling that they didn't get the information they needed when they needed it. Multiple clients still don't know what evidence the RCMP has in its possession that should be returned to them, just one example.

You've heard several stories of Constable Bent offering speculative information which could have no basis in fact, such as speaking to another family about his theory that John and Joanne were the first to be killed by the perpetrator or that maybe Tom was found without his boots because possibly they flew off when he was shot because sometimes that happens. Or maybe there was a relationship between Kristen and the perpetrator because we just never really know people.

These sorts of speculative comments should never have been uttered by Constable Bent.

And there are other perhaps less jarring examples of the failure of the family liaison officer role such as failing to align methods or modes of communication with the needs of the victims such as amongst our client's group, and apparently reliant upon electronic communication when that wasn't accessible to all individuals.

The inadequacy of the execution of this role, we submit, is apparent in the treatment that the RCMP deemed appropriate to properly serve Constable Stevenson's family. Our clients will tell you, it was very painful for them to learn that Constable Stevenson's family was treated to family liaison officers. And I want to be

very clear, not a one has ever suggested that her family was over-supported, but their pain comes from the inequity in care and compassion extended to them by the RCMP as they struggled to get what they needed from a single under-trained and overwhelmed family liaison officer.

I want to point out as well, that the evidence supports the survivors of the mass casualty event were largely neglected by the RCMP. You may recall a rather jarring moment in Constable Bent's testimony when he gave evidence that he had no idea who Darrell Curry was, who we would submit was the RCMP's own victim. By all available accounts the majority of mere survivors of the mass casualty event didn't garner attention from the RCMP at all.

You heard Darrell, Greg and Richard's testimony where they described being left with no assurance of their safety by the RCMP or any information that the event was gone, but for their own personal contacts.

There's a similar experience with Carol and Adam who were also left with nothing but the good graces of their friends and families to tell them that they were safe. And I want to stress that Carol and Adam's experience has the added layer of them hiding in their home for days repeatedly calling the RCMP begging for it to return to investigate their property to ensure it wasn't boobytrapped by the perpetrator so that Carol and Adam were safe to leave their home.

We submit that I could easily do an entire presentation on these sorts of after issues from the mass casualty event, but I want to take a few minutes to speak about prior to the mass casualty event and the inadequacies and deficiencies which our clients submit are present prior to what happened in April of 2020.

To touch upon them at a very high level we submit that the evidence substantiates numerous missed opportunities to properly investigate and build knowledge about the perpetrator prior to the mass casualty event. The perpetrator was no stranger to policing agencies and there was other information available which should have been accessible to or accessed by the RCMP and given it pause.

He was convicted for assault in 2001 assaulting a teenage boy. There was reports of the threat to his parents reported by an uncle and repeated by his father who also advised the perpetrator had firearms, a report that went virtually uninvestigated. There is the “kill a copy” bulletin, a report which flowed through the Truro Police Service, to the Halifax Regional Police and to the RCMP where it fizzled into nothing.

Then there’s the report of Brenda Forbes who provided a domestic violence report about which the RCMP also appears to have done nothing, and we submit that we heard very questionable evidence from Constable Maxwell suggesting that this was nothing more than a traffic-related issue in spite of his notes being more consistent with the account given by Ms. Forbes.

We have the irrational confrontation between the perpetrator and the Halifax Regional Police in February of 2020. And we also know that there are materials in the evidentiary record which identify the perpetrator as having been flagged by the Canadian Border Services Agency. And I would just reference smuggling and drugs is some of the words that appear in that report.

None of these are petty matters, Commissioners. Our clients submit that all of this prior information taken together and properly investigated could well have revealed the perpetrator to be a person of concern. We submit that the RCMP, either directly or through its lack of accessing of other databases and lack of interoperability with other policing agencies, had the perpetrator on its radar and yet this radar appears to have been turned off again and again. Whether this is because he was a wealthy white man who cleverly presented as pro-police and who enjoyed the special attention of an RCMP constable or whether the RCMP or other policing enforcement agencies just didn’t take the time to note and actually investigate these red flags. The result is the same. The perpetrator was subject to no real scrutiny at all and was left free to devastate our communities as he saw fit.

Commissioners, I want to shift gears a little bit and start driving

toward a conclusion.

I want to take the time to express some of our clients' concerns about the integrity of the evidentiary record and the tone of the process more generally. And I bring these comments to you today to -- so that you -- we can ensure that you understand what our clients need to see at the outcome of the Commission's work.

For all the evidence gathered and which we have argued earlier today, we appear -- we suggest, is incontrovertible. You'll not be surprised to hear me reiterate concerns we have made before and our clients have made before about information we have not had the opportunity to know, more specifically, in a complete and reliable manner.

Our clients don’t need to be told again that this process is not an adversarial trial like one, or that their role is not that of an adversary, but they submit that that does not negate the need for them to take all reasonable steps to ensure that the evidentiary record, which underlies the Commission's work, is reliable, and to get there, that it is verified and tested.

In this instance, numerous documents have been entered into evidence without being verified by witnesses. Countless interviews have formed part of the evidentiary record, with the exception of a few statements or excerpts occasionally put to witness. They haven't been adopted under oath by witnesses on the basis of avoiding doing harm and providing the best conditions under which to receive evidence. The testing of evidence by participants has been blocked in critical cases, such as S/Sgt. Rehill, Sgt. O'Brien, and Lisa Banfield.

And we submit that there are also instances of the Commission declining to pursue evidentiary opportunities, such as rectifying what could be an integral discrepancy, as in the case of Reginald Jay, or such as where we have questioned whether the Commission has explored areas fully enough in the first instance, such as the relationship that each of the Tuck, Oliver, and Bond families had with a particular community member.

Other loose ends about which it is unclear if the Commission is intending to tie up such as pursuing further accounts of the disputed April 28 teleconference, or actively taking steps to determine the fate of the mysteriously missing audio recording of that same meeting, these are loose ends which cause our clients some concern.

Our clients certainly recognize that decisions have been made, and it is too late for some of the pieces of the evidentiary record to be handled differently, in particular, what they submit is the incomplete and untested evidence from S/Sgt. Rehill, Sgt. O'Brien, and Lisa Banfield.

But I repeat these comments to you today because to the extent that the integrity of the evidentiary record can be bolstered on a go-forward basis or that its weaknesses can be addressed in the Commission's final report, we trust that the Commission will hear our clients' concerns and take all appropriate steps to address these weaknesses in the evidentiary record in its final report.

I want to speak for a moment about some of the revelations that have come to light recently about the Department of Justice of Canada and how it has handled its contribution to the Commission, which has deeply concerned our clients.

Perhaps most openly discussed is the issue of the apparent miscommunication with Chief Supt. Leather, that according to him, he was advised not to be proactive with the Commission regarding phone calls and emails leading up to the April 28th meeting teleconference with Commissioner Lucki, or his interview in support of the review, which produced the Quintet Report.

Our clients can't but wonder if someone as senior as Chief Supt. Leather was advised not to volunteer information, who else might have been? And they submit that there's every reason to be concerned that someone with less seniority and job security would feel able to inform the Commission of what they thought was an omission, like Chief Supt. Leather did.

We learned quite recently about redactions having been completed

to the notes of Deputy Commissioner Brian Brennan without his involvement or his input, such that he couldn't speak to them during his live testimony before the Commission. And our clients are left to wonder if one witness was not consulted in the redaction of information that they produced, how many others might there be? What information might witnesses think they've shared with the Commission that their counsel has actually redacted?

On that note, there are concerns about the content of redactions too. There is the example of the Quintet Report, where redactions were completed in excess. Now, we thank the Commission for openly addressing this issue, which appears to now be resolved with respect to that particular document, but our clients are left wondering where else may there be redactions that were over-applied that may not be readily apparent to a participant or even the Commission?

There's also concerns about the timeliness and completeness of disclosure such as the significant examples of the disclosure of additional handwritten notes of Commissioner Bergerman late at night in the middle of her long-planned testimony before the Commission and the late disclosure of emails with Commissioner Lucki, again, only shortly before her testimony, after she had been interviewed by the Commission.

These occasions give our clients reason to question how thoroughly the Department of Justice of Canada pursued its disclosure obligations. Results of the recent revelation of the Commission's request for an RCMP organizational chart, which was raised by yourself, Commissioner Stanton, you advised it was something that had been sought for some time, which Commissioner Lucki expressed surprise you didn’t have, which she said existed in one form or another for some time.

To the extent that these examples call into question the Department of Justice of Canada's efforts at providing full and complete disclosure, this is obvious concerns for the Commission's ability to do its work effectively. Our clients remain

deeply concerned about the Commission being wound up with these sorts of loose ends remaining, and to the extent that the Commission cannot resolve them before its work is complete, our clients strongly hope that any evidentiary weaknesses created by the perceived or actual lack of transparency and completeness of the disclosure by the Department of Justice of Canada is openly addressed in your final report.

Finally, Commissioners, beyond these more tangible concerns about the evidentiary process, as you know, a number of our clients have felt that their faith in the process has been shaken by feeling marginalized and devalued at various stages of the Commission's work. You may not share those feelings, but it is important to my clients that I ensure that you hear their concerns today. For many, faith in this process is dwindling, if not lost, and if they are to restore that faith and find themselves able to have confidence in the final report of the Commission, they need to know that they've been heard.

From our clients' perspective, they feel that opportunities to participate have not always been appropriate as mandated, such as the decision to block their questioning of witnesses by their counsel or to refuse questioning of witnesses in public proceedings at all, such as in the case of Cpl. Peterson.

Some families feel that they've been given a one-size-fits-all approach to their participation, to how they share their knowledge and experiences with the Commission. You'll recall their hearty rejection of the proposed small group session format in June of this year. It's not lost on our clients that this was later replaced with yet another one-size-fits-all option.

The irony in that is everything the Commission has heard about needing to understand victims as individuals with individual circumstances and individual needs, yet our clients feel the Commission has not afforded them this.

With respect to individual clients, some of them have similarly felt disregarded by the Commission.

Bernie passed away in December of this year. Not one expression

of interest in hearing from him was received by our legal team.

In Mallory's case, we had to urge the Commissioner to interview her a few months ago.

It is difficult for clients who had to ask to be heard to feel like the Commission truly values their experience, particularly in light of the numerous other community members the Commission has invited into its public proceedings to effectively speak for people like Bernie and Mallory, which they never asked for.

You'll have also heard concerns, Commissioner, about the amount of time spent on Phase 2 related matters, and we've spoken about this in our written submission conveying our clients' view that in a number of instances, the Commission has gone far afield in its exploration of those issues.

And of course, our clients understand there's a mandate and that there is issues included in there that you didn't choose, that you don't have the luxury of choosing which of them you're interested in exploring. But our clients submit that the Commission did, however, have the luxury of choosing how they explored those issues, and it's in this context that our clients feel the Commission went too deep into the recesses of various issues, giving this platform to other interest groups to advocate for their own priorities.

Some topics, of course, were completely relevant; for example, the time learning about what a public alerting system is, how it can and should be implemented, was obviously time well spent.

But in other instances, the discussions simply were too far gone. It's difficult for me to explain to my clients how engaging in discussions about child poverty and experiences of non-hetero-normative individuals in rural communities can approve the particular weaknesses in our policing agencies and our broader society that potentially enabled this mass casualty to happen. And my clients submit that they're not alone in their concern for the Commission's veering of course, as has been seen in public commentary including from professionals and academics such as Professor

Wayne MacKay and Professor Ratushny.

Perhaps it's not a coincidence that on the same day as the rurality and community wellbeing roundtable that I just mentioned that Professor Ratushny spoke of his assessment of the Commission expressing that sometimes you get the feeling that this is some kind of academic fairyland. Now, whether you agree with Professor Ratushny or not, or any of us do, we submit that the Commission cannot but take notice of the fact that these respected scholars felt the need to express critique of this Commission's path, which is consistent with our clients' feelings.

And let me be very clear, Commissioners, lest there be any misunderstanding of my intentions, neither me, my firm, nor my clients are diminishing the value of any of the conversations that have taken place here. The problem that our clients are submitting is that they didn't all have a place here and they -- these conversations occupied space that should have been spent on things like gathering other evidence.

Finally, Commissioners, our clients -- a number of our clients have expressed the concern that they feel that they've treated like children, that decisions have been made for them about what dignity they or their loved ones should have or not have, or what will be too harmful for them, or that they've been counselled directly or through their lawyers about their behaviour, sometimes even before proceedings occurred. This treatment has been deeply offensive to a number of our clients who feel that the trauma-informed lens has been applied to them with the same care as other participants.

It's not been lost on our clients that criticism levied by them has -- levied against them hasn't been addressed by the Commission. And I offer the specific example of what the O'Brien family argues is the maligning of them by the National Police Federation when the O'Brien family publicly shared the Fitbit data it had and its dismay that the Commission had seemingly ignored it. Nothing about the O'Brien family statement crossed any lines, yet the Commission appears to have done nothing about

the impropriety of the allegations thrown at this family by the National Police Federation.

It's also of concern for our clients that, in at least one critical incident, the Commission appears to them to have created a breeding ground for public critique of our clients, and that example is the Commission's handling of Ms. Banfield by which it declined to provide any meaningful explanation for why she would be isolated from questioning by participants, leaving it only as a vague statement of it being the most effective way to gather Ms. Banfield's best evidence. Our clients submit that that smacked of distrust of the intentions of either our clients or their counsel, or both, and that was picked up by others. We heard that criticism as recently as last week when our clients' interest in learning all that Ms. Banfield could provide was implied as misguided -- is in the realm of victim blaming and forcing victims to recount and have every single trauma-related detail aligning with maybe a previous report to the police as was discussed during Ms. Fifield's presentation on behalf of the Avalon Sexual Assault Centre.

And you will not have missed the public commentary of Ms. Banfield's counsel, James Lockyer, I'm sure, who complimented the Commission's ambiguous decision and inexplicably labelled our clients as having only conspiracy theorist goals comparable to the type that have arisen in response to mass casualty events south of the border, which we don't need in Nova Scotia for anyone, least of all the Toronto lawyer engaged to speak for a witness intensely protected by this Commission. To apparently feel that the process has given him licence to compare our clients and their search for answers to groups like Sandy Hook deniers is disgusting.

Our clients have only ever pressed the Commission to engage Ms. Banfield as a witness and allow participants the ability to fully explore and test her evidence, consistent with basic principles of procedural fairness, and our clients feel that for the Commission to manage her evidence in such a way is to make our clients appear untrustworthy or irrational in their search for answers was a failure to afford our clients the same care and respect as Ms. Banfield and that therein her interests were

protected at the expense of theirs.

Commissioners, I've highlighted our clients' concerns because while it's too late for some things, the Commission still has time to consider its focus and approach in time for a comprehensive final report, one which, to the fullest extent possible, honours our clients, their lost loved ones, and their continued suffering, and ensure that positive change comes from the heavy, hard work that has been done here.

Commissioners, now is not the time to shy away from assigning accountability for the fear that it might have the appearance of blame. Now is not the time to liken doing one's best with doing everything that could have and ought to have been done. Our clients deserve a frank and honest assessment of what went wrong prior to, during, and after the mass casualty event, one that is not clouded by academic discussions about issues that don't really get to the bottom of what happened or that don't clearly identify what we need to do to prevent the thing that happened from happening again.

We urge you, Commissioners, to keep those you have designated most affected at the forefront of your minds as you work toward your conclusions and recommendations.

I can't but note that we're here on the 20th of the month and it's by sheer coincidence that we're not here on the 19th of the month. We're here speaking to you during that span of days that serves as a painful monthly reminder of the days that changed our clients' lives forever. But the fact that our clients have turned out in droves can't have escaped your notice. In spite of feeling disenfranchised and disappointed with decisions of the Commission, our clients are still here to ensure that this Commission does the work that they fought for it to do. The continue to show up and urge this Commission to make the hard findings and make the hard recommendations to achieve the public safety that we all deserve regardless of who may be affronted by them, whether that's the RCMP or anyone else.

Commissioners, our clients may not get more from the RCMP than

isolated acknowledgement like Lia Scanlon's recognition that, upon reflection, communications weren't adequate, or Chief Superintendent Campbell's for "failing you" and his assurance that "we'll do better". Our clients may not get more from the RCMP, Commissioners, but they can get better from this Commission.

We respectfully submit that the Commission must follow Chief Superintendent Campbell's lead and call a spade a spade when it comes to the mistakes made and the changes that the RCMP must make going forward and design recommendations accordingly.

And those are my submissions. Thank you.

COMMISSIONER MacDONALD: Thank you so much, Ms. McCulloch, and thank you to your clients as well for their presence here today.

Mr. Bryson, I believe is next. Yes.

--- SUBMISSIONS BY MR. JOSHUA BRYSON:

MR. JOSHUA BRYSON: Good morning, Commissioners. My name is Josh Bryson. I'm here with my colleague, Aaron Wagner. We represent the family of Peter and Joy Bond, and we mostly deal with their two sons, Harry and Cory Bond.

So those five areas I wish to cover today, the first being identification of critical incidents; the second is IR training and response; third, perimeter containment and scene security; fourth, next-of-kin notification; and finally, the perpetrator's history. All sections will have some recommendations that I'll further flesh out in my written submissions.

So starting with the identification of critical incidents, the OCC and, in particular, the risk manager have the responsibility of identifying an event as a critical incident. And we have two documents in relativity that speak to that. That's COMM64611 -- that's a document from J Division in the context of critical incidents -- and also, from National Headquarters, we have another document. Both define critical incidents as an event or series of events which, by their scope and nature, require a

specialized and coordinated tactical response.

The UK College of Policing takes a more holistic approach and defines a critical incident as any incident where the effectiveness of the police response is likely to have a significant impact on the confidence of the victim, their family, and/or the community. And I'm drawing this from the literature by Laurence Alison and her publication. It's COMM58377. There's other authors as well. It's "Imagining Grim Stories to Reduce Redundant Deliberations and Critical Incident Decision-making". This approach properly places value on the efficacy of the police response and the public's confidence in their police force when dealing with critical incidents.

I'm going to revisit this when I address recommendations in this section. So it appears to be a broader focus than simply police deciding, "Are we unnecessarily dispatching resources when faced with a critical incident?" You must engage in a more holistic approach, I'm suggesting, and consider additional variables.

The OCC did address some changes. And their response does appear to be designed and aimed towards critical incidents. There are several documents, Comm 62294 and Comm 63180; there's 47 changes to operations. However, the changes appear to be mostly designed to assist after an event is identified as a critical incident, not all, but that appears to the be the lens by which these changes were made to OCC.

The gap that I see is the policy and training that results in that initial determination of whether something is a critical incident or not. When you receive that 9-1-1 call at 10:01 p.m., do you have the grounds to then treat it at that point as a critical incident. And that's what I wish to flesh out.

So in this particular case we know, in this tragedy, at 10:43 p.m. on April 18th Risk Manager Rehill broadcast on the Colchester Comms that Danko was activating ERT and the Critical Incident Command. That's at 10:43.

So I'm just going to digress for a moment on that chain of command. So improvement had been made but in this particular -- during this tragedy

the chain of command was unwieldy. In order to even activate the critical incident package you had to go from Rehill, Halliday, West, Campbell. That's four layers of hierarchy that you had to travel through to get the critical incident package initiated, which is completely unacceptable. And that continues too. When you look at -- like, for example, we had Deputy Commissioner Brennan testifying and he was asked, "What, if any, role do you play during your Mass Casualty event?"

And his response, well, he assesses if the division requires any additional resources. And in order for that request to be made to Brennan, for example --- and in this case we had to go through Rehill, Halliday, West, Campbell, Leather, Bergerman, and Brennan. Brennan's not finding out about this Mass Casualty until after the death of Cst. Stevenson, so at roughly 10:50 a.m.; so seven layers of bureaucracy in order to engage with National Headquarters to be advised if they require resources or not. So how is that a meaningful involvement of National Headquarters in a Mass Casualty like this, when you have to go through seven layers of hierarchy to see if your H division requires resources?

That's something I request to be addressed and has to change. It's not responsive; it's not timely. This is almost 13 hours after this Mass Casualty began. And this is when Deputy Commissioner Brennan is being engaged.

So back to the deployment of the critical incident package. So at 10:46 p.m. West contacts Superintendent Campbell to authorize the critical incident package. Commander West testified before this Commission. Commission counsel Burrill asked West, :So you had no problem suggesting that this met the criteria for the critical incident package?"

He replied, "Yes."

He is then asked, "And was that on the basis of one call?"

He replied, "Yes."

And that's at Comm 58603, page 24. And that does appear to be true for West, as we know that he didn't even know about the Andrew and Kate

MacDonald interaction that occurred at the roadside when he was agreeing to activate the critical incident package. He was missing that key detail.

So he basically drew from the first phone call. It appears that the first phone call formed the basis for why the critical incident package was initiated.

Superintendent Campbell also testified before this Commission that the initial 10:01 p.m. 9-1-1 call met the threshold for the critical incident package to be engaged at that time. And that's at page 131 of Campbell's testimony.

So if the grounds existed to initiate and treat this as a critical incident response as of 10:03, why wait until 10:46 to initiate the critical incident response; that's a 43 minute delay. This issue is very important for future mass casualties as police are very likely to be notified about the unfolding mass casualty by way of a 9-1-1 call from an unknown third party who provides hearsay information. That's what happened in Moncton. It was a 9-1-1 call.

The call taker has no idea as to credibility or the veracity of the information. So this intake is vitally important to get right. And that's where I'm suggesting that training and revision of policy can take place. The information has to be analyzed quickly and a determination made as to whether it's a critical incident. If it is, don't wait. And that paper I'm going to get into talks about redundant deliberation where you're basically spinning your wheels. We call it procrastination. You're not really furthering your knowledge base. Time is passing, nothing is happening.

Seconds matter, as we know. In the 45 minutes it took to activate this critical incident package 13 people in Portapique were deceased already.

If we look at Ms. Blair's 10:01 9-1-1 call she's calling as a firsthand witness. She describes her husband being shot. He's down. She's identifies the neighbour as the shooter, identifies him as a male, and that he's a denturist. She says she saw him coming up on her deck with a firearm. Ms. Blair provides her address; she confirms her cell phone number. She's clearly genuinely extremely afraid. There's crying and the call ends with screaming.

Police run some checks. They look at PROS; there's nothing on the PROS to suggest that this is an individual with a history of mischief or a history of providing false statements to police. Police ping the cell phone and it pings to the address that Ms. Blair provided to 9-1-1. And this is confirmed in the Colchester comms.

Police also obtain subscriber information for the cell phone which comes back to Jamie Blair. So all of this should provide some circumstantial markers of reliability. You have identity of both victim, subject of complaint. You have an address that makes sense in the context of the complaint. You have a cell phone number that's tied to the address. And the caller comes across as genuinely afraid.

There is absolutely no basis to believe that the caller may not be telling the truth in this instance. If you accept what Ms. Blair is telling you, the situation is dire. And her life is at stake, and the life of others. In this case, the information describes a critical incident. Ms. Blair gives you everything you need and the information appears to be credible. There's no reason to speculate that it's a mental health call, that perhaps there's another member that's involved, or redundantly deliberate on the nature of what you're dealing with.

Analytically assess the information that you have. Corroborate what pieces you can. And it may be able to stand on its own. I this case, I submit that it did -- could stand on its own. And in this case, even if some caution was warranted, we have the follow-up call at 10:16. This is a second caller. This is the child that's calling now saying that their parents were just killed, referencing a fire and referencing -- also referencing a cop car. So this is by 10:16. So now we have two different callers describing a critical incident, and the critical incident response is not yet initiated.

And also, in regards to that call, the arriving members by 10:22, 10:23 are on the comms saying, "We can see fires." That corroborates the child's phone call at 10:16. ID this as a critical incident; don't wait.

In the article, "Imagining grim stories to reduce redundant

deliberation and critical incident decision-making", its authors, psychologists and criminologists note that a persistent criticism leveled at some or all emergency services during response to these critical incidents are a failure to act in time or even act at all. Two studies are cited for this reference. Redundant deliberation -- they define it as -- it's the pathological overthinking, a choice between difficult options. It occurs when there's no standard operating procedure and is intensified by the fact that decision makers are not exposed enough to these events to build the repository of expert knowledge.

It describes the single most damaging decision making failure, and we didn't just see it here with the critical incident activation. We saw it with Twitter, the inexplicable delays in issuing that 10:17 tweet. The redundant deliberation is leading to a failing to act in time or at all. It causes, in the authors' note, reputational damage to the individual decision maker and their organization and further catastrophic loss of life. It may not even be a conscious choice by the decision maker. And perhaps this applies to the Ready Alert as well.

There were discussions at around 10 or 11 o'clock on the 19th, but there were still redundant deliberations by the RCMP withholding and not issuing that Ready Alert.

Some may suggest that the definition of the critical incident or that the incident is in fact a critical incident doesn't matter. They may suggest, well, police responded to the scene as fast as they could to deal with it. But that omits the fact that these delays cause a delay to the tactical response, but it also causes general duty members to take a wait and see approach, which we can see in the Colchester Columns and also the Cumberland Columns.

So for example, Corporal Jamieson at 10:06 p.m., this is just minutes after the Ms. Blair call ended. It says, "Once you guys have an idea of what you have, just let us know and Nobuk(ph) will assist with whatever we can do." The offer was not accepted at that time.

At 10:24 Corporal Jamieson again states: “Do you want us to start heading that way? We can look for the vehicle or help you guys out there?” Response: We’re probably – actually, I’m really close; we’ll just standby there right now and we’re going to approach here in a second and we’ll go from there.

So why isn’t the risk manager who has command and control of this operation dealing with these available resources? We’ve heard about resource was an issue during this mass casualty. There’s many examples of available resources just waiting to do something. Constable Grund later on when he wants to form a three-person IARD team and enter Portapique. It was all wait.

The resources on hand were not being used and if they were used, it was too late. The members wanted to help immediately. There was no command in control of all available resources. Another example is the Cumberland RCMP at 10:37 on the comms, Cumberland does not appear to be formally engaged. On the comms it reads: “When you guys get clear of that, you may want to make your way to at least the border”, referring to the Cumberland-Colchester County Line.

The fact that this wasn’t determined to be a critical incident as soon as reasonably practicable caused delays in deploying available resources of the scene, both at the general duty member level and also by the tactical teams.

Superintendent Campbell testified, “You’re asking me about best practice; it’s all hands on deck, especially when you have an active shooter, so every gun, every member should have been in the hunt to stop him”.

We recommend that OCC consider their policies and training that leads to defining an event as a critical incident, what events require corroboration by attending members and what events don’t and if the caller describes a critical incident or there are circumstantial markers of reliability with the information provided. Some of the details you can corroborate forthwith such as a person with no history of committing crimes of dishonesty; they’re not trying to remain anonymous, they don’t sound impaired, they come across as genuine, and they’re expressing a first hand account as

a witness. That seems to have reasonable markers of reliability, information that you can accept and initiate the critical incident response.

At a high level, examine the core principals in dealing with a critical incident. Perhaps reflect a more fulsome understanding as to what these responses mean to the community as per the U.K. policing definition of critical incidents, which defines a critical incident as any incident where the effectiveness of the police response is likely to have a significant impact on the confidence of the victim, their family and/or the community. Recognize that the only drawback here is not simply unnecessarily dispatching resources, there's other costs as well.

Recognize the intrinsic value in your community having confidence in you and imbed that into your analysis of whether to classify an event as a critical incident. So there are my comments with respect to OCC.

In regards to IARD. We've heard from members of the RCMP about their actions during the mass casualty. We haven't heard much evidence about the best practices in a situation such as this. So we heard from Beselt, Patton and Merchant, three of the first four members of on scene, they formed an IARD Team. They indicated that it was in accordance to their training. We do have some training materials and more actually that were just uploaded last night. Operational manual Chapter 1610 is the policy regarding immediate action and rapid deployment. It defines it as the swift and immediate deployment of law enforcement resources to an ongoing life-threating situation where delayed deployment could otherwise result in grievous bodily harm and/or death to innocent persons.

The policy is not meant to be a comprehensive guide for members to follow but provides high level guidance to members.

At section 3, for example, such as gathering information and continually assessing the situation, s.. 3.13, "immediate deployment of resources to stop the active threat."

We heard from the IARD Team during the witness panel on March

28th that they themselves made the decision to proceed into the community on foot in pursuit of an active shooter due to other incidents such as Moncton, New Brunswick, Spiritwood, Saskatchewan where officers were shot in their vehicles. They had encountered Kate and Andrew MacDonald upon arrival and were advised at that time that the perpetrator was mobile in a police vehicle but decided to pursue the perpetrator on foot. And it was excruciating for them. They testified that they covered over ten kilometres by virtue of this decision. They also testified that they had over 70 pounds of gear with them at the time.

They testified that there was no ability for them to be tracked by GPS and they couldn't track other members moving throughout the community. They had no night vision FLIR and it was dark. They also had to make the decision at various points in the evening to continue to search for the perpetrator in accordance with IARD principles and checking on the four children sheltering in place. And we now know based on the materials that have been disclosed, that it is planned to actually have more than one team enter into and respond to a critical incident. You can have more than one contact team; you can have multiple contact teams and you're also trained based on the materials we've seen in relativity, to have rescue teams.

Also at one point the IARD Team encountered who they believed to be the suspect. It turned out to be Clinton Ellison with a flashlight. The IARD Team members yelled, "Is there anybody else in here with us? Identify yourself right now". Mr. Ellison then proceeded into the woods. IARD ceased their pursuit of him, testifying that it would be suicide to do so as they could have been ambushed by going into the woods.

As defined in section 1.9 of the RCMP Operational Manual, the priority during an IARD is to stop the active threat. At 11:21:18 p.m, 18 second p.m., Sergeant O'Brien denied the entry of a second IARD Team out of concern for crossfire. And that's at comm.306, line 833. Respectively, he was not in a decision to make that call. He was not at OCC. He was off duty. He had consumed four to five drinks of

alcohol. The evidence is suggesting that he felt that he wasn't impaired. Other members of the RCMP state that they don't have concerns because of the evidence that he wasn't impaired.

From a lay person's perspective, that sound respectfully preposterous. If I showed up here today and told you I had four to five drinks of alcohol before giving my submissions, you'd have grave concern.

Commissioner MacDonald, if I appeared in your court after consuming four to five drinks of alcohol, you'd be concerned.

Commissioner Fitch, if I reported to you when you were police chief and with four to five drinks of alcohol within the last four hours, how is that not a common sense determination that Sergeant O'Brien should not have been on the Comms?

There was concern expressed by members about his involvement. I don't recall which IARD member, but we played the recording during the Portapique foundational document and the response was, after Sergeant O'Brien had again chimed into the comms., the response was, "We know Andy". In other words, the tone was, can you please lay off? He continued to interject here with things that aren't helping us.

This decision should have been made by the risk properly informed. The person in charge of command and control should have been made by the risk manager who had the most situational awareness of the commanding officers that were jumping into this fray.

So at the time of Sergeant O'Brien's denial, the location of the perpetrator was unknown; the members in Portapique continued to hear bangs they could not decipher. The Blair and McCullough children continued to be sheltering in place. They reported hearing sounds. It is clear that on the ground this appeared to be an ongoing active threat that required an IARD response.

Section 1(4) of the RCMP Manual states:

"To maximize public safety, the members should

consider backup from other trained resources based on a continuous risk assessment. Officer safety is essential to public safety." (As read)

In addition, section 3.15 states:

"Immediately deploy available resources to stop the active threat in accordance with section 1.9 in IR training." (As read)

And again, as I said, prior to Sgt. O'Brien's denial, Cst. Grund had inquired about sending in a second IR team and advised that there were three members who could have formed an IR team to enter into the community.

Cst. Dorrington can also testify that he was prepared. He disagreed. He was brave to testify and state that he disagreed with this decision to deny entry to a second team. He was prepared to go in as a team.

We also have an affidavit that's been uploaded to relativity. It's the affidavit of Scott Warnica. I don't recall the highest level he reached with the RCMP. He had roughly 30 years of policing. He may have been a commanding officer. But he talks about IARD.

And in regards to sending in multiple teams he states -- and this is found at COMM54270:

"First three people go in as a team, it depends. But as people show up, the person that's actually looking after the scene can either send in a second team to ---"

And in this context, it was a building ---

"--- the other end of the building, or say, 'No, wait until we have -- until we hear more shots'" (As read)

The follow-up question was, "How many teams can you have go in? Is there a number?"

Answer, "There is no number. Until you run out of members."

> "But I mean, you don't want to send in four teams or maybe even two teams into a small school. Then you're creating a crossfire situation. Like, in a school, for instance, you're coming at one end of a hallway with another member coming at another end." (As read)

And there, there was no reason why a second team could not proceed down Orchard Beach. You have one team going down Portapique, send another team into Orchard Beach. That seemed to be -- had the tools been used, pictometry, any sort of mapping tool, you could see that those routes do not intersect. What was the risk of crossfire by taking that approach, at least consenting to a rescue team to go in to rescue those children?

It doesn't appear as if IR training -- it doesn't appear that IR training has been assessed in light of this mass casualty. IR training was addressed in the MacNeil Report. Recommendation 6.4 states that:

> "Immediate action, rapid deployment training be adapted to include various environments, as well as decision making, planning, communication, asset management, and supervision components to ensure members work through constant risk assessments in an operational communication centre. Training and coordination response to high-risk incidents should be conducted at the same time as IARD." (As read)

We do have an affidavit of Inspector -- an inspector with the RCMP. It's dated August 11th, 2022. It outlines some of the changes to IARD since the MacNeil report, and that's outlined at paragraphs 90 to 94.

There were changes to make IARD mandatory. There were

changes in 2017 to have indoor and outdoor IARD training.

In 2020 -- I don't believe we have policy on it -- but we have an indication that training was again updated to specifically address IARD room entries and clearing. This is at page 94, IARD rescues, and a half-day IARD refresher course was added to the block training 2020 program to ensure members' IARD skills would be maintained, as IARD is a one-time only course.

There's no evidence to suggest that this is reflective of the lessons learned from this particular mass casualty. It's recommended that IARD training be updated to reflect the lessons learned. It can include components such as nighttime IARD training. I see no record that nighttime IARD training is now in place, and the only reference I see to nighttime training is ERT's nighttime training with air support. There's no mention of IARD being included in this nighttime training.

The training should also reflect the realities of what equipment the division has. Right now, it's understood that each division -- sorry, each detachment has one pair of night-vision goggles. So presumably night training would be without this tool.

Training should definitely include rural settings that are heavily wooded. Training should consider when it's appropriate to send in multiple teams, and who makes that call. Training should address whether it's appropriate to proceed into a large rural area on foot or be mobile. They're areas to be assessed.

Run tabletop exercises at depot or during IR training, using Portapique as an example. If IARD hasn't evolved since this mass casualty, it's concerning.

And what role does the risk manager play in making these decisions? If we look at Inspector Rodier's description of the risk manager program -- this is in a description dated September 7th, 2021 -- it indicates that:

> "The risk manager will immediately take command and control over the situation, deploy resources,

> direct the response. They will call in or redeploy resources to allow for an increased response. They will make final decisions on when members are called out to a scene. They will make operational decisions in regards to whom and how many, if any members are called out." (As read)

If the risk manager is to have a role to play with IARD, I suggest it was lacking in this particular case.

So those are my comments with respect to IARD.

I wish to touch on general scene security. When Commissioner Luckie was testifying, I had pointed to several prior inquiries, reports, that had recommended general scene security be analyzed by the RCMP, and unfortunately, and as of the MacNeil tragedy, that had not occurred to the extent that members were aware of scene security, and that the policies were put in place.

And again, in 2020, in this mass casualty, we have the issues we've spoke about, about the potential crime scenes in Portapique not being -- efforts not being made to discover those potential crime scenes, and specifically, Cobequid Court.

So given the history of the prior inquiries, prior reviews, it's quite baffling to the Bond family that no one turned their mind to securing all potential crime scenes within Portapique.

Throughout these proceedings, we heard from members of the RCMP that concerns with interoperability played a role in deciding not to deploy or rely on municipal policing agencies.

Scene containment, and a proper and timely canvassing of all residents in Portapique is one area that would pose very little issue for interoperability. On July 28th, 2022, Leather testified that he did not see risk associated to what was just described to him, namely, would there be interoperability concerns with asking Truro Police to canvass Portapique? There were no concerns with that expressed by Chief

Supt. Leather.

The RCMP did not rely on their municipal colleagues to assist with this task, which resulted in delays.

Where resources are finite -- and we've heard about finite resources throughout -- there has to be partnering with municipal agencies, but it has to be ingrained in the culture. If you don't have the members on -- with you, if you don't have the resources on hand, it should be second nature to reach out to your partnering agencies for the greater good, for public safety.

On April 18th and 19th, Nova Scotians didn't care who was protecting them, as long as there was someone protecting them and keeping them safe.

The fact that potential crime scenes were unsecured is also clear from the fact that we don't have inner containment on April 19th within Portapique. COMM53537 is a photo I received from a journalist that I disclosed to the -- to this Commission. It's a journalist that was able to drive down Brown Loop Road and on to Blueberry Field Road at 2:04 p.m. on April 19th without issue.

So this is very troubling. At this point, the Oliver-Tuck scenes, the Bond scenes, were not secure. Other homes were not canvassed, and individuals are able to drive right into Portapique and get a -- before -- this person ended up just turning around on their own, but to get -- and drive down the Blueberry Field Road.

Several commanding officers testified that they did not turn their mind to scene security, which is absolutely astounding. And that came from Sgt. O'Brien.

Sgt. Carroll also seemed to be -- to struggle with that. He didn't see the need to take further steps and make canvassing and securing potential crime scenes as a priority.

The RCMP does have a scene security policy. It's Comm 39856; it's dated April 23rd, 2014. It speaks to this. It speaks to the fact that potential crime scenes must be secured.

It doesn't appear that this policy has been formally updated since this date, although Deputy Comm. Brennan did indicate that some changes to scene security have been implemented. And that's at page 50 of his examination.

Sorry, my papers are getting a bit dishevelled here. I'll just find it.

It states that:

> "Things that we learn obviously from the examination of the mass shooting in Nova Scotia engagement in terms of putting specialized resources on the scene, the scenes that needed to be looked after, ensuring that we had resources from our forensic identification section, specialists to go in there under that crime scene security, utilizing members, reaching out to the province and saying, 'Are there other peace officer resources that we could possibly draw on to do crime scene security at the known sites so that we can deploy our operational members into the investigation?'" (As read)

So he gives these as examples of lessons learned from this Mass Casualty.

So given the existence of policy in April 2020, it's not simply whether the policy has to be updated but it's ensuring that your commanding officers understand your own general scene security policy. The existing policy appears to be sufficient at least to address the issues of immediacy in containing possible scenes. So training is the shortfall that I see, Commissioners, in this regard.

And in regard to Comm. Brennan's testimony, I did not come across any sort of written record of what the changes were; just his evidence. So that may be helpful for the Commissioners to receive to help to consider what if any changes should be made and to address further gaps. They are my comments with respect to

scene security.

Next of kin notification is the next area I wish to address. So in regards to the Bond family, there was a suggestion in the material that I received that a next of kin notification in regards to the Bond family went out on April 19th. And I wish to say that that is completely inaccurate and I'd like to spend a bit of time fleshing that out.

So I've come across two recorded phone calls to police by the Bond family despite their evidence that they made numerous calls. So the first call we have is the 10:41 a.m. April 19th call from Cory Bond, that's Comm 2886. It's a call to OCC -- this is what the messenger reports.

> "Parents Peter and Joy Bond live in Portapique and he cannot get a hold of them." (As read)

That's at 10:41 a.m. on April 19th. That call was never returned.

The next call is noted as Comm 4517 page 6. It's an email from Michel Williams, Detachment Assistant on April 20th. It's dated 9:05 a.m. It says:

> "Harry Bond called. He's worried about his parents. Hasn't heard anything and plans to drive down shortly." (As read)

Harry and his brother did in fact drive down. And it wasn't until the afternoon that he knew his parents were deceased. Harry provided a statement to the Commission and said that one of the worst parts of this besides losing his parents was the not knowing, and the fact that he had to drive to Portapique with his brother with some other family members which is a two and a half hour round trip by the time he picks up his brother and arrives in Portapique.

Now, the evidence of this call from April 19th comes from Cpl. Rose-Berthiaume. But he's equivocal in his statement. It's Comm 57748. At one point he states:

> "I believe I spoke with either the Tucks or the Bonds. I believe it may have been Harry Bond." (As read)

And he recounts a conversation where he confirmed that two people were deceased but that ID was not confirmed. And respectfully, I believe Cpl. Rose-Berthiaume was confused on some details. He may have spoke to Harry midday on April 20th as Harry does recall receiving information when he's entering Portapique that there were two deceased persons found in the residence, but that identify was not confirmed. There was no call on April 19th, and if we look at Cpl. Berthiaume's notes, he notes that he did speak with Crystal Mendiuk at 11:30; that's in regards to the Oliver Tuck family. And that's what his notes indicate.

He does not have the same notation in regards to a next of kin for the Bonds in his handwritten notes. He has Harry's name in his notes along with other contact names for some of the other families but his notes do not disclose a next of kin for the Bond family.

And most importantly, Harry Bond would remember receiving this information on April 19th, obviously, that his parents were deceased. He wouldn't be calling Truro the next day and he certainly wouldn't be driving the next day with his brother and other family members to get to Portapique.

So the issue we've identified with respect to next of kin are timeliness. The RCMP had a record of Cory Bond's call the morning of April 19th at 10:41 a.m. Unfortunately, it was not returned. There was no further -- there was nothing done in regards to that particular phone call. It wasn't even cited as a reason why they went down Cobequid Court ultimately and found the Bonds at 4:46 and the Oliver Tuck family at 4:50.

So the concern -- and I addressed this in questioning -- so the RCMP are holding press conferences. They're identifying loss of life. They're extending condolences in visits they've made to one family in particular. When the Bonds don't even have the next of kin notification from the RCMP as to what -- they're still looking for details in regards to their family. And this is on April 19th after -- this press conference was several hours after the Bond family were discovered. Timeliness

-- that has to be a priority.

The second issue is the manner in which next of kins are delivered. It's not safe or appropriate to have it go on this long. You have to anticipate that family members, if they're going to embark on a several hour road trip, engage in this type of effort to figure out what happened to their family. The next of kin notification should be properly tasked, coordinated, and efforts to deliver the notification should be made immediately, especially before press briefings are given that serves to identify some victims and some measures, some references made to console, properly to console victims, of course. But please do so in a manner that respects all families.

The final section I have is that prior dealings between the police and the perpetrator. So we are concerned with the RCMP's prior knowledge with police agencies' prior knowledge of the perpetrator. We've heard through witnesses with the Mass Casualty Commission and through testimony during the public proceedings that there were at least three complaints made. Ms. McCulloch spoke to them -- the 2010, 2011, 2013.

The 2010 was when the perpetrator's uncle Glenn complained to the Codiac RCMP that the perpetrator intended to travel to Moncton, New Brunswick to kill his parents. This 2010 incident is outlined in detail in the foundational document "Violence in the perpetrator's family of origin." I actually won't repeat the facts here. I think we're all largely familiar with the facts of that particular incident.

So this report outlining the original complaint was shared with HRP in the Bible Hill RCMP detachment.

Sgt. Poirier of the Halifax Regional Police attended the residence of the perpetrator and Ms. Banfield's residence in Dartmouth. It was noted that there was a possibility that the perpetrator was in possession of long-barrelled weapons. When Sgt. Poirier attended the residence he was advised by Lisa Banfield that there were no weapons in the house but she would neither admit nor deny the threats against his parents, is my understanding.

Ms. Banfield testified on July 15th before this Commission. She told Sgt. Poirier that there no weapons in the home despite knowing that the perpetrator had a handgun in the nightstand.

HRP took carriage of the file since the phone call originated in their jurisdiction and the Bible Hill detachment was advised that they did not need to check on the perpetrator's cottage in Portapique.

At 4:41 a.m. on June 2nd, 2010, a record was added to HRP's data base advising that the perpetrator may be of interest to Halifax Firearms police. Sgt. Poirier checked the Canadian Firearms Registry online, confirmed that the perpetrator did not have a licence to acquire or possess forearms, and did not have any registered firearms.

A few days later, Sgt. Poirier spoke to the perpetrator on the phone, was advised that he had a pellet rifle, two antique muskets. They were not operable. Ms. Banfield testified that Cst. Wiley, a friend of the perpetrator, attended their cottage in Portapique in response to this complaint. Sgt. Poirer's notes state that he contacted Cst. Wiley to inquire whether the perpetrator possessed any firearms.

Ms. Banfield independently testified that she was present when Cst. Wiley attended the cottage and recalled the perpetrator advising Cst. Wiley that he had a musket and a gun above the fireplace filled with wax as a decoration. She also testified that she did not see Cst. Wiley conducts an independent search. She did not speak to him separately either.

We also heard from Cst. Wiley on September 6th. He did not recall attending the perpetrator's cottage for the purpose of speaking to the perpetrator about this. However -- in fact, Cst. Wiley had no recollection of ever addressing this.

I submit that we have two different people giving -- so we have Ms. Banfield and we have Sgt. Poirier giving two independent recollections of the matter. They corroborate each other. Cst. Wiley's involvement, what he says is his involvement, I question. I'm not suggesting it's a deliberate effort to deceive. I don't

know what the intention is but what I'm suggesting is that the two versions you have that corroborate each other, I believe are the best versions given their independence from each other. Sgt. Poirier -- Sgt. Wiley's -- Cst. Wiley's evidence in this regard is not reliable.

We then have the 2011 bulletin. We also have the complaint made by Ms. Forbes. We heard from both Ms. Forbes and Cst. Wiley in regards to this. Cst. Maxwell will testify that he visited the perpetrator's residence to essentially, I guess, make observations, to see if he could observe this offence being committed firsthand. And then, following that, it was important to him that he contact the perpetrator to advise him that this complaint was made against him.

Cst. Maxwell will testify that he did not catch him committing an offence so essentially there was nothing for the RCMP to do and I submit, respectfully, that's not the standard in policing. That's not the only type of evidence we use to charge and prosecute people, firsthand accounts of officers. The courts everyday have cases based on witness observations and witness testimony.

Cst. Maxwell's notes are limited but do contain the names "Glen Wortman, Richard Ellison and Lisa". He could not recall why they were there but was adamant that the complaint was about the perpetrator's driving. He also noted that the complaint involved, in fact, a decommissioned police vehicle, but Ms. Banfield testified that the perpetrator did not own any decommissioned police vehicles until after this incident.

The discrepancy in Ms. Forbes recollection of the complaint and Cst. Maxwell's is concerning, especially since the officer's notes are so limited and contain names of individuals that Ms. Forbes says was involved, names that she would have provided. This is another incident where the perpetrator was reported to police but I submit that police took insufficient action to investigate the report by Ms. Forbes.

And even if you accept Cst. Wiley's version, it was still insufficient. There was a drive-by and that was it. Nothing further was done. No efforts were made

to contact any of the witnesses. The recommendation that I have in this regard -- and this could be very broad but it's in regards to ensuring that a proper investigation be completed so I'm going to flesh that out a little more in my written submissions, including making sure you have contact with the victim of the complaint and ensure that you're following up with witness statements.

In each of these incidents, we have clear information that the perpetrator was possibly violent and possibly in possession of firearms reported to police. It's been argued that because the RCMP and police agencies did not have sufficient ground to obtain a warrant on these occasions, then it's unreasonable to suggest that the risk the perpetrator posed was knowable or that law enforcement could have averted subsequent events. We respectfully disagree with that assertion.

A search warrant is a gold standard. A search warrant can be why you conduct an investigation. That's the fruits of your labour, a search warrant. There's many other methods to conduct an investigation, most of which don't start with a search warrant -- caution statements of the perpetrator; canvassing for witnesses; if the matter permits, surveillance. There's many other methods before an investigation may elevate to that of a search warrant that were not employed here. So the fact that there weren't grounds for a search warrant, I submit, is not an excuse for the action or inaction take here.

And then it becomes a self-fulfilling prophecy because if you're improperly investigating the file, and closing it on that basis, of course it's going to be caught by your retention -- your file retention two-year policy. There's nothing to retain. The retention policy is not a bar here. We have to go further in behind that to say, "Well, let's look at the matters originally and why weren't they investigated." Had they been properly investigated, perhaps there would have been charges. Perhaps there would have been other content that would have formed part of a permanent file. We don't know.

At a minimum, this investigation could have generated further

information for police when they were responding to the April 18th mass casualty when they heard the name from Ms. Blair, when they heard the name from the Blair and McCully children, and also Andrew MacDonald.

Thank you, Commissioners. That's everything that I wish to speak to. I'm going to be addressing this and more in my written submissions. So subject to any questions, there are my comments. And thank you for your time today?

COMMISSIONER MacDONALD: Thank you, Mr. Bryson.

We'll take a 15-minute break.

And I understand, Ms. Miller, you'll be up after the break.

Thank you.

THE REGISTRAR: Thank you. The proceedings are on break and will resume in 15 minutes.

--- Upon recessing at 11:20 a.m.

--- Upon resuming at 11:38 a.m.

THE REGISTRAR: Welcome back. The proceedings are again in session.

COMMISSIONER MacDONALD: Thank you. Welcome back.

Ms. Miller, whenever you're ready.

--- SUBMISSIONS BY MS. TARA MILLER:

MS. TARA MILLER: Good morning, Commissioners. My name is Tara Miller, as you know. I'm with my colleague, Alix Digout. We represent a family member of Kristen Beaton, and that family member is Beverley Beaton, her mother-in-law.

April 18th and 19th, 2020, will forever be marked in Nova Scotia by the devastating loss of 23 lives. The lives lost included Kristen Beaton and he unborn child who were murdered at 10:00 a.m. on Sunday, April the 19th. Their deaths will forever impact Kristen's entire family, her husband's son, brother, sister, father and other mother, our client, Beverley Beaton.

The death of 22 people and baby Beaton, came at the hands of a monster. When such evil reigns, we turn to those trusted with public safety to protect us. However, in this case, a cascade of failures, errors and missteps by the RCMP fundamentally impacted the trust Nova Scotians have in the RCMP to maintain public safety.

We now have a deeper understanding of the circumstances which unfolded over the 13 hours from 10:00 p.m. on April the 18th, until 11:30 a.m. on April 19th, and the years that passed before that time.

We also have a more robust understanding of how the RCMP's response played an unfortunate, but very tangible role in the devastating losses suffered during the mass casualty and in its aftermath as family members navigated the unimaginable loss of their loved ones.

Our submissions today will address five topics, some of which had a direct impact on the untimely and preventable deaths of Kristen and others. And those topics will be RCMP accountability, two, communication failures, particularly addressing two sub-issues, one relating to the gathering and sharing of critical information, and secondly, with respect to the alert ready system. Thirdly, resource issues specifically relating to Pictometry. Fourth, police education. And, fifth and finally, post event support for family members.

While our submissions on these issues and others could certainly take hours, to make the most of our time this morning we'll focus on specific examples from the evidence in each of these areas, followed by suggested recommendations for consideration by the Commissioners. Our written submissions will contain further detail and recommendations that we don't have time to canvas today.

So I'll move first to RCMP accountability. It's clear the RCMP's organizational structure and culture played a significant role in the outcome events on April 18th and 19th. Critical to restoring confidence for Nova Scotians and all Canadians will be to ensure that not only meaningful recommendations are made, but that the

RCMP are held to account to swiftly and purposively action those recommendations to protect Canadians in the future.

This is a concern shared by RCMP members themselves. Corporal Tim Mills was the ERT Team Leader on April 18th and 19th. A seasoned RCMP member with over 29 years of service, including ERT response in the Mayerthorpe and Moncton tragedies, Corporal Mills expressed poignant concerns about a perceived futility that recommendations stemming from this inquiry will not result in change.

His quote from his evidence on May 16th, "So Moncton was somewhat similar but not to the scale of this and things never got rectified that were identified in the MacNeil decision. And that's where my frustration was voiced. In my belief, you know, nothing will change after this either. So you might get a couple of little changes out of it. I was an ERT member during Mayerthorpe and seeing all those recommendations, hardly seen any changes. I worked Moncton and seen all the recommendations, hardly seen anything. So my belief and what will come in this after the fact, and if it will be followed up, you know, followed up with recommendations, I don't have a big belief in that."

We share Corporal Mills concerns that recommendations flowing from this inquiry will not be actioned or implemented. The evidence supports a reasonable conclusion that recommendations flowing from a variety of past RCMP reviews, reports, inquiries and investigations have had challenges with implementation and execution.

We anticipate that the Department of Justice will likely argue recommendations are dutifully implemented following reviews and inquiries. In reality, and in keeping with the evidence, this only appears to be the case on paper in many cases. Instead, many RCMP members responding to the mass casualty were unaware of relevant recommendations and/or the public safety background relating to them.

This is notwithstanding evidence from RCMP senior management that recommendations are viewed as part of ongoing learning with requirement for

members to read the reports.

Additionally, some reports themselves directly state, “This is not a one-time read or nice to have, it’s the very core of frontline policing in today’s environment.”

I’m going to review two examples, Commissioners, directly applicable to the mass casualty events that relate to decision-making with communications and road checkpoints and prior recommendations and reports. Notwithstanding several other possible examples, we highlight these two specific examples as had they been implemented, it’s reasonable to conclude that they would have had a direct impact on minimizing lives lost and the outcome of the mass casualty.

I’ll start with the issue of communication and decision-making. While there will always be a chain of command, members operating within that chain and within their roles, should be given autonomy for decision-making during critical incidents where seconds are precious to avoid the loss of life.

That autonomy is consistent with the 2015 C-3 Command Control & Communications Response & Planning Guide which was developed by Atlantic CROPS Officers in the fall of 2015 based on best practices and lessons learned from major police incidents throughout North America.

Then Nova Scotia CROPS Officer Chief Superintendent, Marlene Snowman, was one of the four authors of the guide. Her Nova Scotia successor was of course Chief Superintendent, Chris Leather, who took over in 2019. We heard that he had no knowledge of this Guide until after the mass casualty when it was brought to his attention in 2021 as a result of production requirements for the MCC.

The guide is predicated on a principle of C-3 leadership, the basis of which is receiving information, making timely decisive decisions and communicating these decisions as direction to those entrusted to carry out the action, as well as receiving feedback about that action.

C-3 is less consultative than other forms of leadership, simply

because urgency of action often does not permit consultation. Chief Superintendent Leather's evidence agreed that C-3 leadership would absolutely have applied to the mass casualty event.

The bureaucracy of the RCMP seems to serve to encumber independent decision-making as was evident on April 18th and 19th when multiple people were required and involved in the decision-making process, which translated into a blurred and quite frankly confusing command structure for members and the public.

No more poignant example of this was the evidence around the drafting and dissemination of the critical tweet with details of the perpetrator's car which was posted to twitter at 10:17 a.m.

The creation and dissemination of this tweet involved tasking, delegation, input, drafting and approval between seven people over a two-plus hour period. The evidence overwhelmingly supports the conclusion that Kristen Beaton, aware of the Portapique shootings, was actively following the situation and taking steps to ensure she, her family and her work colleagues were aware and safe. Shortly before 9:00 a.m. on April 19th she posted information on a Facebook website linking an RCMP twitter page.

By 9:37 she was aware of the perpetrator's name, had a picture of him and knew that he was the RCMP suspect in the Portapique shootings. Kristen was sitting in her car on Plains Road in Debert while she searched online and through social media for additional information on the perpetrator and his whereabouts. What she was not aware of, and did not find on social media, was that the perpetrator was driving an RCMP vehicle which was identifiable by a specific call sign behind the rear passenger window, and that he was likely wearing an RCMP uniform. The information Kristen was seeking to protect herself with, had been in the hands of the RCMP since approximately 7:15 to 7:27, that's what the evidence shows.

By 8:00 a.m. direction had been given by Staff Sergeants Halliday and MacCallum to communicate the details of the decommissioned police vehicle and

RCMP uniform use to the public because of how important it was.

By 9:40 a.m. a communication team member had drafted the tweet and sent it to Staff Sergeant MacCallum for approval. When she did not hear from him, she forwarded to Staff Sergeant Halliday at 9:45 a.m. for ASA approval, which she received by 9:49 a.m. However, instead of posting the tweet at this point, she sought a further level of approval from Lia Scanlan. This approval came 28 minutes later at 10:17.

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

The amount of time it took to draft the Tweet after S/Sgt. Halliday's initial direction was inordinate, over an hour and 40 minutes. However, once approval was given, the 28-minute delay in posting it was as a result of the communication team member seeking additional approval on an already approved Tweet because of an assumed rule of thumb requiring more approval for bigger events.

The communication member's evidence was that while this rule was not based on any written policy or procedure, it was a rule, a rule that wasn't written down, but a rule that was understood, and as she stated, "And that was definitely something I understood while I worked there, was that if the higher profile the incident, the more approval was required, and there was no way I was going to send that Tweet without her, Lia Scanlan, knowing what I was doing."

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

Chief Supt. Leather agreed the significant delay in sending this critical Tweet occasioned by the communication member's understanding that she had to seek an additional level of approval was an example of where the C3 Leadership

Model should have prevailed to remove unnecessary levels of approval. He knew this, but the member did not. We need to make sure that this does not happen in future critical incident events.

I'll move now to my second example, dealing with checkpoints.

The establishment of road blocks and checkpoints during the mass casualty was, at best, reactive, and in some cases, too late. We heard evidence that responsibility for establishing checkpoints during a critical incident was that of the Critical Incident Commander. The evidence of the Critical Incident Commander on duty that night confirmed that the purpose of checkpoints was to monitor entry and exit points of major transportation routes of where a suspect may be going, and to monitor traffic looking for a suspect vehicle.

At 2:20 a.m. on April 19th, it was known the perpetrator had family in New Brunswick and had threatened to kill them prior. It was also known that the perpetrator had a home in Dartmouth. HRPD were tasked to establish a perimeter around the Dartmouth residence. A checkpoint had been established at the Cobequid Pass.

By 6:44 a.m., Lisa Banfield advised ERT members of an express intention by the perpetrator to kill her sister, who lived in Dartmouth. While steps were taken to ensure Ms. Banfield's sister was removed from her home, nothing was done to establish a checkpoint at the Truro Bible Hill Highway intersection, where the perpetrator would have had to have travelled to move from northern Nova Scotia towards Halifax.

S/Sgt. West, the Critical Incident Commander, acknowledged that this was an intersection that could have been covered with an officer in a mobile unit dispatched to monitor that entry/exit point.

Finally, at 9:42 a.m., RCMP were aware of a suspicious RCMP vehicle near the scene of a deceased female in Wentworth, Lillian Campbell, which "left to head to Truro".

Again, no steps were taken to action a checkpoint at the Truro Bible Hill intersection. Instead, all available RCMP members were directed to the Plains Road area with no direction or thought to monitor an entry and exit point on a major transportation route that was known to be a route the perpetrator would have to travel.

The end result, as we know, was that just before 10:15 a.m., the perpetrator drove, unnoticed, in a marked police car, to an obvious and predictable point on a transportation route which had been known about since at least 2:20 a.m. in the morning, and could easily have been monitored by a checkpoint.

While it seems like a checkpoint at this location should have been obvious, the failure to action such a checkpoint was even more egregious in light of a recommendation flowing from the 2014 MacNeil review. As we know, the MacNeil review stemmed from a mobile shooter event in Moncton in June of 2014. The detailed report contained many recommendations, including 3.6, which stated:

> "Where it does not already exist, each division should establish a policy and protocol through an emergency operational plan to identify entry/exit points in major transportation routes that should be alerted and monitored in the event of a relevant crisis." (As read)

In January of 2020, four months before the mass casualty event, the RCMP provided an update on the status of the MacNeil recommendations, noting the detachment emergency operational plans had been amended to address that recommendation.

Despite this, neither Critical Incident Commander S/Sgt. West or Surette were aware of this recommendation, or of the emergency operational plan being identified to -- sorry, being developed to identify entry/exit points in major transportation routes. Their evidence was that neither received any training or instruction on the MacNeil review. What they had read was at their own initiative. They were unaware of whether the MacNeil report recommendations were implemented in Nova Scotia or

whose role it was to implement them.

Notably, S/Sgt. Surette received his critical incident training in 2015, after the MacNeil review. He did not recall any of the MacNeil review being part of his critical incident training. They both indicated that the MacNeil review was never presented to any of the incident commanders in Nova Scotia.

Commissioners, I review this in the detail that I have taken to highlight and underscore a very important point. We fundamentally believe the failure to implement these recommendations in practice had a direct impact on the events and deaths which followed after the perpetrator passed through Truro.

Public trust in the RCMP has eroded significantly because of the mass casualty events, and understandably so. This trust has been further eroded with the realization that recommendations arising from valuable work done in connection with prior reviews of the RCMP actions following previous active shooter events have not been meaningfully actioned in Nova Scotia.

The end result of the hard work done by all involved in the Mass Casualty Commission will ultimately be recommendations made by yourselves. These recommendations and how they are actioned will be the legacy of the mass casualty tragedy, and how they are actioned -- sorry and the legacy of those whose lives were lost. If there is no confidence or faith the recommendations will be meaningfully actioned and implemented, then the work done by all and the deep losses suffered by the families will all be for naught.

That cannot be the legacy left.

The implementation of the Mass Casualty recommendations will also amount to lip service if members are not fully informed, educated, and trained on the changes. Education must be built into the Commission's recommendations from a structural perspective. To that end, we make one key recommendation, and others will follow in our written submissions.

But we are suggesting that the Commissioners consider a

provincial-federal implementation committee be struck to ensure recommendations made and then implemented are not lost with the passage of time, and/or with a change in leadership at the RCMP, or with a change in government. Such a committee should be comprised of representation from all stakeholders, from National Headquarters, from H Division, from command leaders in Nova Scotia, and most importantly, representation from those affected most by the mass casualty.

It's also suggested that their mandate include updating the public with an annual report, and also having a website for communication.

I'll move now to the two communications issues that I want to speak about, Commissioners, and I'm going to start with a quote from George Bernard Shaw. And the quote is, "The single biggest problem in a communication is the illusion that it has taken place."

Starting with the gathering and sharing of critical information, the volume of information we know received by the RCMP on April 18th, as well as how it was gathered and shared with others was a significant issue. It's clear from the evidence that systems and members did not communicate efficiently.

The problem with information sharing started with the first 9-1-1 call from Jamie Blair at 10:01 p.m. and continued through the remainder of the mass casualty event.

Highly relevant details were relayed by Jamie Blair, Andrew and Kate MacDonald, and the Blair and McCully children about the perpetrator within the first 30 minutes, including identifying markings on his vehicle.

This important information was not meaningfully captured and/or disclosed to responding members of subsequently to those in command. No one was provided with a summary of the initial 9-1-1 calls or was able to listen to them first-hand. The ERT team was stood up at 10:45 p.m. and on the road from Halifax at 11:20. However, the team did not receive any pertinent information about the perpetrator until they reached Truro which would have been sometime after midnight.

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

Important information was provided to the RCMP in various ways, 9-1-1 calls, live interviews, et cetera. Yet this information was not shared competently, and in some cases at all. A key area for recommendation for the Commissioners is obviously to consider what can be done to ensure proper communications processes are in place so that large volumes of information can be accurately summarized and passed down the line to those individuals who need it to make informed decisions and give precise orders.

To that end, the recommendation we have in terms of a suggestion, Commissioners is that as a starting point and specifically with respect to critical incidents, that a specific individual be designated as an analyst and tasked to review 9-1-1 calls in a timely manner to compile a detailed list of key information which can then be used to accurately brief others from that point forward. This avoids the effect of telephone when critical information is either never captured accurately or is lost as multiple people convey their perspective of the information to others who in turn do the same.

I'll move now to Alert Ready, the second component of the communication piece.

The fact that none of the command structure was aware of the availability of the Alert Ready system is astounding. The default response by RCMP management during proceedings has been that it was not a tool in their toolbox as they were completely unaware of it as an option. This is incorrect and frankly unacceptable in light of clear evidence that an intrusive Alert option for active shooter situations was presented to the RCMP many years prior to April 2020 and as early as 2012.

We know from questions answered by Mark Furey that on January

4th he sent then -- S/Sgt Mark Furey sent a briefing note to Criminal Operations dealing with public alerting which identified three categories of an alert including an intrusive alert which could be issued when there was an immediate or potential risk to life. He was recommending follow--up on this and his evidence was that this was not well received and ultimately led to his departure from the RCMP.

His comments are consistent with the evidence of Paul Mason, the Executive Director of the Emergency Measures Operation who gave evidence and recalled that S/Sgt Furey said that the alerting system would be an asset to law enforcement in meetings that he had with him. And of course, we've heard evidence from Paul Mason that there was a presentation done to the RCMP or for the RCMP in June of 2016 and that the RCMP were included in meetings moving forward where that topic was discussed.

Truro and Halifax Regional Police were aware of the availability and utility of the Alert Ready system. The only entity seemingly unaware of the availability was the RCMP. The fact the RCMP as an organization chose to ignore the availability of Alert Ready as early as 2012 is a bigger issue than just the impact it had on public safety on the April 18th-19th weekend. It warrants a finding that the RCMP were willfully blind and made a choice not to adopt or learn more about this system, a system which would have been an asset to law enforcement had they chosen to pursue it.

The RCMP had a clear duty to warn the public but failed to do so. It's more than reasonable to assume again that the loss of innocent lives would have been less, had an alert gone out on the morning of April 19th.

It's comforting to know the Nova Scotia RCMP now have trusted user status for issuing an alert. It was also reassuring to see the RCMP use public alerting in a timely manner in the recent James Smith Cree Nation and Weldon tragedy. It was not comforting, however, to hear Chief Superintendent Leather respond to the question of if the same exact events happened today with the new policies and protocols in place would an alert be issued, with his answer, "It's not clear cut that an

alert would have been the right tool to be using."

After all the evidence the Commission has heard, including the timeline of information known by the RCMP through the early morning hours of April 19th, we ask that the Commission make as a finding of fact that the events of the Mass Casualty in April 2020 should have necessitated an alert well before the perpetrator became known to become active again at approximately 9:30 a.m. in the morning of April 19th.

We will detail more recommendations on this topic in our written submissions, but one key one we want the Commissioners to consider is that the RCMP in Nova Scotia as a system trusted user should take responsibility for its own public education program, working in collaboration with the Emergency Measures Office and the Department of Justice. This would include using its own website to distribute education information, to fulfill the vital education component of any alerting system as was reviewed in the detailed evidence on the use of public alerting in Australia from Michael Hallowes.

I'm going to move now to the topic of resources.

While the evidence highlights significant issues with -- sorry, the evidence highlights there were of course significant issues with resources ranging from resources that were either not available to resources that were available but were not accessed in a timely manner or at all. As a result, members' ability to respond in an optimal way on April 18th and 19th was adversely impacted.

Rectifying some of these resource issues will take funding, no doubt. But other resource issues will just take training. Members cannot be set up for success if they're not provided with the right tools for the job. And this includes knowing the full extent of the tools in their toolbox.

My focus today is on one key area and that is the topic of pictometry. We've heard much evidence on the challenge of rural policing given geography, funding, and people power constraints. Colchester County is the second

busiest county for policing outside of the HRM and covers a significant expanse of rural area. Member, we have heard, had limited, if any, familiarity with the Portapique area. When the four responding officers entered Portapique on foot they did so largely blind. They had no night vision coggles and no access to working maps while on foot. They resorted to using their personal cell phones to identify various locations within the community.

Based on the Commission's working timeline, these officers arrived in sequence at 10:25:27 p.m. and they were joined by Cst. Dow, a fifth officer, at 10:43:52 p.m. Again, working with the Commission's timeline, the perpetrator was thought to have left the community at approximately 10:45 p.m..

These five officers had the best opportunity to identify and apprehend the perpetrator. However, their ability to do so was significantly hampered by a lack of resources, a key one being visibility on the access points into and out of the community. These five responding officers and all who followed thereafter understood there was only one way in and out of Portapique. This error was perpetuated by the Risk Manager and OCC who relied on outdated mapping technology which in turn left responding members with incorrect information relating to containment of Portapique.

This was despite having access to mapping technology known as pictometry which clearly showed the alternate access through the Blueberry Field Road. The pictometry technology was not accessed, and as concluded in the April 21st, 2022 Mass Casualty Supplementary Report:

> "…would have given the RCMP a better understanding of the road networks in Portapique, thereby enhancing containment efforts during the Mass Casualty events." (As read)

We heard that there were varying reasons why pictometry was not used on the night in question. Jen MacCallum and Risk Manager S/Sgt. Rehill at OCC had challenges accessing it. However, had this key technology key been activated at

the start of their shifts, it's reasonable to conclude that any IT issues could have been addressed well in advance of the 10:01 9-1-1 call from Portapique. Other members appeared to have limited, if any, knowledge as to how to use Pictometry, such as S/Sgt. Carroll.

The use of Pictometry on the night in question should have been non-negotiable. Its value is even greater in a rural policing environment where street signs and mapping are not as prevalent as found in an urban centre. What Nova Scotians expect, and what the RCMP must insist upon, is that members are well trained in all available technology and use that technology regularly. That costs nothing.

Sgt. Briers was an example of a member who was well trained in Pictometry and used it frequently prior to the mass casualty. One can reasonably assume that had S/Sgt. Briers been the risk manager on the evening of April 18th, he would have been able to access the Pictometry system to identify and direct successful containment of Portapique in a timely manner.

From a recommendation perspective, we suggest that consideration be given for a direction that the familiarity, training, and use of Pictometry or any more enhanced mapping technology should be mandated, particularly in rural detachments for all levels of members in senior command. And secondly, enhanced IT training, picking up my friend, Mr. Bryson's, comments, should take place with a particular focus on rural, nighttime, and mobile perpetrators with Pictometry as a mandated part of training and tabletop exercises.

Moving now to the fourth category, and that is police education. We've heard that policing has changed significantly over the last few decades. This was covered in the June 30th rountable on rural community safety and policing. Supt. Dan Morrow, a member with 30 years of policing experience, shared his observations with the change in policing. He said:

> "In those 30 years, the landscape has completely changed from I joined. I didn't know what a cell

> phone was or an email. Now we are responding to calls for service that actually originate from international jurisdictions as cyber offences have increased, targeting our elderly and our youth, the same with equipment. The technology, again ever changing, hard to keep pace with, and the costs have increased significantly." (As read).

Dr. Rick Ruddell addressed the expansion of expectation for the police over the last number of years in the same roundtable, noting:

> "What we're seeing the past few years is a decrease in the public's trust and confidence and their perceptions to the performance of the police. The complexity of the job has increased. The expectations of the public have increased. The expectations are higher. The public's perceptions are lower." (As read).

Roundtable members also spoke about the need for enhanced training on the law for RCMP members, such as Dr. Signa Daum Shanks:

> "While much has changed in policing, the timeframe for new officer education at Depot remains at six months. This raises the fair question of whether the current education at Depot is the best we can do or should do to ensure public safety for Canadians." (As read).

Kimmo Himberg, the retired Rector of the National Police University College in Finland, indicated at the June 1st roundtable on critical incident response that each Finnish officer has a minimum of three years' training at the university before they are enrolled in the Finnish Police Force. He said:

> "In Finland, according to international measurements, public trust, citizen trust to the police is the highest in the world. Ninety-one (91) percent of Finnish citizens trust the police a lot, or close to that." (As read).

Why is that?

> "Our understanding," he said, "is that one of the reasons is that we educate officers extensively. Basic police education leads to a bachelor's degree in Policing and takes three years. There is lot of more theoretical and practical content in the program, and we put a special emphasis on values and attitudes in education." (As read).

Commissioners, we submit that we need to pay attention to the correlation between citizen trust in the police and enhanced education, particularly as we try to mend this relationship between citizens and our National Policing Force moving forward.

As a suggestion for recommendation, we suggest it's time for training requirements to expand, and that means additional time at Depot and/or more focused training afterwards. We strongly encourage the Commissioners to consider recommendation that fundamentally alters the breadth and depth of current RCMP police education.

The last area I will cover, Commissioners, is family post-event support.

The importance and sensitivity of family management was addressed in the January 2020 review relating to the homicide of Colton Boushie, and I'll quote from that report:

> "In general, a homicide victim's family often experience a great deal of uncertainty about an

> investigation as protecting its integrity obligate police to withhold detailed information from all people. The family may have to endure media pressures, public rumour, and speculation about circumstances surrounding their loved one's death. The victim's family may have to process their grief all the while coming to terms with the perhaps unexpectedly long periods of time that are required for complex homicide investigations to properly complete. All of these things can cause stress for the family and, in general, can potentially undermine their confidence in the police and their support for the police investigation. A purposely-built trustful relationship between the police and the family will generally facilitate better communication within these contexts of grief, stress, lack of information, and uncertainty." (As read).

We submit that a significant amount of the families' post-tragedy grief centered around the lack of transparency, insufficient information, or support from the RCMP. It's safe to say a purposefully-built trustful relationship between the families and the RCMP did not exist. And part of the reason for that was the way in which Family Liaison Services were handled.

The family members reeled in the immediate aftermath of the mass casualty as they learned of the loss of their loved ones. Their trauma was magnified by the manner in which RCMP communicated with the families and handled next-of-kin notification, family liaison services, and crime scene management. Again, I will use specific examples relevant to our client.

Cst. Bent was the sole officer assigned to act as Family Liaison Officer for all families. He had no training specific to acting in this role and, at least in

the days immediately following the tragedy, he was also tasked to do other roles. When the -- while the RCMP offered to have another member assist, Cst. Bent declined.

The experiences of the Beaton family and others navigating the aftermath of the mass casualty is heart-wrenching. The flow of information from the RCMP was significantly lacking, leaving families to repeatedly call 9-1-1, the RCMP, and the Truro Police, and to resort to social media in an effort to learn information.

The Beaton family experience included family efforts to locate Kristen which began shortly before 11:00 a.m. on Sunday when information filtered to the family that she had be killed before that point. Her brother drove to the scene of her death shortly after 11:00 a.m. to provide information about Kristen, including her name and the car she was driving. He provided his contact particulars so that the RCMP could follow up with him. No one did. At 11:32, Kristen's husband, Nick, called 9-1-1 to inquire about her. He was told that the information would be forwarded to members on the ground who would follow up with him. At 11:48, Mrs. Beaton's employer called 9-1-1 to report her missing and provide details of the vehicle she was driving.

At 12:49 p.m., Kristen's employer was aware from the RCMP that she was no longer missing. Despite this, Kristen's husband and family members did not receive confirmation of her death until 6:00 p.m. that day. Her husband was told that he would be "happy" to know he was one of the first ones to learn of his loved one's death. He waited eight hours to officially learn what he feared the most, despite the RCMP having identifying information about her for hours and having advised her employer at 12:49 that she was no longer missing.

Other families encountered similar experiences which included official next-of-kin notifications not happening in a timely way or not happening at all. Some family members had guns pointed at them when they attended at murder scenes desperately seeking information about their loved ones. The perpetrator's face and name were well known at this point, so there was no way this response was as a result of mistaken identity.

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

Further anguish was caused when property was returned to families with crime scene remnants. This was the case for the Beaton family as they collected Kristen's vehicle with signs of her trauma still in it. Her husband was left to collect her personal belongings from the crime scene and clean them.

The experience did not get better as communications to the families was less than ideal. The families struggled to get information. Kristen's husband and family learned much of the detail about what was happening by watching the news. He was told by Constable Bent to turn on the news as new information about the mass casualty was going to be released, leaving him to find this information out at the same time as the rest of the world.

As we turn our minds on how to make sure the unnecessary further agony experienced by the families is not repeated, there is helpful guidance from various components of phase two evidence.

The June 28th roundtable understanding and addressing the immediate and long-term needs of those impacted by mass casualty, is particularly helpful when considering insights and best practices to inform the basis of recommendations for family support.

The importance of accurately and timely communication in particular, was addressed by the panel, and specifically by Levent Altan who reviewed best practices undertaken by other countries for victim support and communication, particularly around information sharing.

Mr. Altan said, "It 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.

He gave as an example of how not to handle communication, what happened in Brussels when a decision was made not to inform family members of the identifications of victims until there was a 100 per cent certainty. This left family members to go to hospitals looking for their loved ones when the police or the coroners knew 90 per cent of who the deceased people were. This magnified the family's trauma and this seemed to have been the experience by a lot of families repeated in Nova Scotia.

The panel's collective experience and expertise reinforced that everyone experiences grief differently with multiple layers, and in their own time and at different moments of time, that even with the passage of time, Nova Scotia remains raw, and as a community we are still in the early days of recovery, with grieving done in a fishbowl. Victims and their families have a need for respectful treatment and recognition and protection from further harm and secondary victimization

And lastly, that recovery from the trauma of the battlefield is not possible when still on the battlefield.

Commissioners, with communication key, we make the following short and long-term suggestions for recommendations to support family members. The RCMP should have update procedures for scene security, clean-up and preservation of victim dignity. Crime scenes with victims' bodies still present should be secured and protected such that video footage and photographs cannot be obtained.

Victims bodies at crime scenes should be treated in a respectful manner with a blanket or covering applied over them immediately after all necessary lifesaving measures and medical attention have failed. Every family should be assigned their own family liaison officer.

The RCMP and Nova Scotia municipal police agencies should develop a family liaison process and procedure guideline providing clear direction for

members acting in this capacity, even if they have not had any formal training.

Members acting as a family liaison should be specifically assigned to this role for an initial period after a critical incident instead of trying to balance other tasks such as was the case for Constable Bent.

The Nova Scotia Emergency Measures Office, the RCMP and municipal police agencies should develop a dedicated non-emergency line into the operational communication centre for family members seeking information in the immediate aftermath of a mass tragedy.

This was a recommendation from a family member themselves. This would allow families to know exactly where to call for updates to speak with someone who has the latest information, a simple communication tool to help alleviate the stress and grief of families seeking information.

Nova Scotia emergency measures, the RCMP and municipal police agencies should develop a victim-focussed communication website with different sections for the public and victims to access relevant information in the immediate aftermath of a mass tragedy, similar to the website in the Netherlands referenced by Levent Altan.

The recommendations from the January 2020 RCMP investigation relating to the homicide of Mr. Boushie relating to family management, death notification and crime scene management, should be reviewed and incorporated into your final report as appropriate for a mass casualty.

And lastly, to the extent possible, the mass casualty should deliver its final report as early as possible, and if possible, earlier than March 31st, as far in advance of the anniversary of the mass casualty event. Only with the delivery of this report will the families be able to move from the early days of recovery to no longer being in the battle field.

To conclude, the work that we have been doing is coming to a close, but we know that you Commissioners have a lot of work ahead, And I echo Ms.

McCullough's plea that the Commissioners make hard findings and hard recommendations stemming from all of the work that we have done. We want to recognize the work done by the Commission and its staff over the last year and a half, particularly during the hearings themselves.

While there have been so many involved, we want to specially note the efforts of Maureen Wheeler, Jenna-Lee Patterson, Darlene Sutherland and Jen Cotterall. These women have provided calm, caring, responsive and steady support to us and to our clients.

On behalf of my colleague, Alix Digout and their entire MDW law team, it's been an honour and a privilege to work with and for our client. And collectively, with lawyers for families who lost loved ones and survivors, to navigate through a process which has been procedurally challenging and frustrating at times.

To the families, your grief is raw and your suffering ongoing and we know how hard this has been for you all. It's clear that Kristen and all the beautiful lives lost brought much joy to everyone around them and there is so much emptiness with their absence. The loss of your loved ones in this manner is unimaginable, yet through your grief it was your unwavering dedication and commitment to calling for this inquiry which has resulted in us being here today. Know that we will support you now and into the future and we'll continue to advocate with you for the adoption and implementation of recommendations flowing from this inquiry so that no more Nova Scotians and Canadians have to suffer the heartache that you have endured leaving a legacy of hope for the future.

Subject to any questions, Commissioners, those are my comments. Thank you for your time.

COMMISSIONER MacDONALD: Thank you so much, Ms. Miller.

And it's 12:27. Ms. Long, good afternoon. We'll break until 1:30 and at that time we'll look forward to hearing your submissions and we'll offer whatever help we can since you're self-represented, to guide you through it. So we'll see you at

1:30 and everyone else of course. Thank you.

REGISTRAR DARLENE SUTHERLAND: Thank you, the proceedings are now on break and will resume at 1:30.

--- Upon recessing at 12:27 p.m.

--- Upon resuming at 1:33 p.m.

REGISTRAR DARLENE SUTHERLAND: Welcome back. The proceedings are again in session.

COMMISSIONER MacDONALD: Thank you. Good afternoon, everyone.

Ms. Long, whenever you're ready.

Whenever you're ready, Ms. Long.

--- SUBMISSIONS BY MS. TARA LONG:

MS. TARA LONG: Hi. Good afternoon, Commissioners, Counsel, family members, and friends.

My name is Tara Long and I am Aaron Tuck's sister and closest living relative, blood or adopted, to my knowledge. I have tried to find Aaron's birth father, but I have been unsuccessful.

I am here because on April 18th, 2020, my brother Aaron, sister-in-law Jolene, and niece Emily were murdered, and after more than two years and millions of dollars spent on this inquiry, I have more questions than answers.

Let me be clear. I don't want to be here. None of us want to be here. I'd rather be spending my time in Truro with my family, hearing about Emily's job as a welder. That's what she wanted to do. I want to be looking ---

COMMISSIONER MacDONALD: I'm sorry. Thank you, Ms. Hupman, and I apologize. You didn't have a microphone for that, and we may just get you to repeat it, please.

MS. LINDA HUPMAN: Commissioners, it's unfortunate that I have to interrupt this presentation, but in our -- and to uphold our obligations to our client and

our representation of them, I must object to any connection or any suggestion of a relationship between Jolene Oliver or Emily Tuck and Ms. Long. It would be extremely traumatic and have negative -- very negative consequences on the family, our clients.

COMMISSIONER MacDONALD: Thank you, Ms. Hupman.

So Ms. Long, I'm going to, as a self-represented litigant -- sorry, presenter, I apologize -- try to give you some guidance. We're here -- just bear with me -- we're here to hear what your experience has been as a participant. You've put on the record, it's already on the record why you are a participant, so I would ask you now to start telling us about your experience as a participant in dealing whether it's with the RCMP, whether -- or not, Victim Services or not. And of course, we're most interested in hearing any recommendations you have that would help us going forward, to make communities safer in the future.

MS. TARA LONG: Without the background as to who I am, I can't tell you about my experience.

COMMISSIONER MacDONALD: Well, we have your background, so now you ---

MS. TARA LONG: My experience is based on the fact I was kicked out of my family when they died, and that I -- Emily Tuck was my brother's daughter. That makes her my niece.

COMMISSIONER MacDONALD: Okay. You've put that on the record. So what I'm trying to do is help you get to the next step, and I presume you have notes there ---

MS. TARA LONG: Oh, I have notes and I intend ---

COMMISSIONER MacDONALD: --- that deal with your -- is based upon ---

MS. TARA LONG: Okay. So I'm just ---

COMMISSIONER MacDONALD: Excuse me just one second -- based upon materials that are before the Commission to assist us in coming up with

appropriate recommendations, okay? Please.

MS. TARA LONG: I hope that you people can live with yourselves.

COMMISSIONER MacDONALD: And Ms. Long, just to help you, commentary like that is not helpful, please, so just ---

MS. TARA LONG: On Sunday morning, I woke up and I got a phone call from a mutual friend asking if I had heard from my brother, Aaron. I started calling and messaging Aaron on Facebook, and I got no response.

I don't have Twitter. I cannot describe the terror that went through me while I waited to hear back about what happened to my family.

I called the RCMP to do a wellness check. I got a phone call from Cpl. Rodney Peterson, who told me he had heard there was an evacuation centre, and he was going to find out if my family was there.

Cobequid Court had been known in the command centre since 2:50 a.m. The CIC Boards for evacuation listed Cobequid Court; however, they never evacuated it, see foundational document RCMP Command Post Operational Communication Centre and Command Decisions, COMM0057771.291.

At the command post, boards were put up that listed addresses for possible evacuation on Portapique Beach Road, Orchard Beach Drive, Portapique Crescent, Cobequid Court, Bayview Court, Faris Lane, and Coast Lane.

Why is it, if there was no gunfire going on and other people could be evacuated, i.e., the Griffins, why would you leave Bayshore Road and Cobequid Court until the next afternoon, approximately 14 hours later?

If you believe the gunman was deceased and there's a period of inactivity, why are you sending members home at 6:30 instead of evacuating residences?

I heard on Sunday night there was a confirmation of dead bodies at my brother's house, so I called the RCMP and I was told that three bodies had been found, but they could not confirm who they were.

To this day, I have not gotten a confirmation of dead bodies or who was at that house.

After having gotten nowhere with the RCMP, I called the medical examiner's office and I was told that they -- since they were on their way to her office, she assumed that they were dead.

I remember asking Skipper Bent at one point -- it might have been Monday -- he asked for a photo of Aaron, and he gave me the email address to find -- to send it to.

In my state of mind, I typed in the wrong email address and the photo never made it to him.

After that, he told people that I didn't send the photo, and I was kept out of any communications that had to do with my family and treated like an outsider.

He later testified that I set up the house cleaning for the murder scene of my family, but I was never even considered a family member, so I didn't have that kind of authority.

Immediately, things didn't add up to me, and as time went by, they made less sense.

The timeline of when events started is hard to pin down. Jamie Blair called 9-1-1 at 10:01 p.m., and we are told that the perpetrator left Portapique area at 10:48.

During this 47-minute period, we are told that a single individual went to 7 locations and murdered 12 people and burned down 4 buildings. That gives 6.7 minutes per location, including travel time.

Were the buildings set on fire before this person went to the Blair house?

Ms. Banfield says that she was on a FaceTime call with friends, and the conversation that took place was the catalyst for the following events. However, there was no record found for this call that I have been made aware of, even

though the FBI has searched. I've asked what time this call took place and I'm still waiting for an answer. This would have been -- the call would have been made using an app so the time it took place should be easy to find.

How did the RCMP rule out multiple shooters? According to Cst. Dorrington in his MCC interview he said:

> "We still have no clarity as to the number of shooters that are involved." (As read)

What were the RCMP doing between the time -- between that time and when the shooting started again the next morning? Why are there so many accounts of gunshots until much later that night? Why was my family not found until Sunday afternoon?

In Cst. Dorrington's notes he has a note about a wellness check called in from Cheryl Blakie at 11:10 a.m. GPS shows Cst. Dorrington stopped in front of the Bond residence for 30 seconds at 10:26, and my brother's house at 10:27 for another 30 seconds. Comm 0058252, he was tasked by Sgt. O'Brian to search for bodies . How did Dorrington not see the bodies of my brother and Mr. Bond in the front doorway of these residences?

Skipper Bent sent a text message to Aaron's phone at 1:15 p.m. on Sunday afternoon to see if they were all right, rather than going to check, when Cobequid had been under an evacuation order for nearly 11 hours.

Cpl. Rodney Peterson says in his affidavit that he spoke to Rodney MacDonald and Trent Lafferty on Sunday and that the perpetrator had a sniper rifle and a 50-calibre rifle, neither of which seemed to have been recovered. And where did this information come from? Where are these weapons?

The East Hants radio logs show that S/Sgt Halliday says the perpetrator was a highly-trained sharpshooter. Where did that information come from? Were there any inquiries by the MCC into these mentions of the sniper rifles or this perpetrator being highly trained? Aaron was found in the doorway of his home. In order

to do the rest of what this person did, he would have had to stand over -- walk over Aaron to get into the house to the other victims. There was no DNA from any of them found on him from Aaron.

According to Aaron's autopsy the first two shots didn't kill him. He would have been fighting the perpetrator for his life and to protect those girls. Were Aaron's hands bagged and checked for DNA?

Aaron rarely smiled in photos because his teeth were in poor condition. And just prior to his death Aaron had his teeth fixed and you can see that in some of his more recent photos because he was smiling. But his autopsy says that his teeth were natural and in good condition.

Greg Piniot and Ashley Wood were the paramedics who drove Ms. Banfield to the Colchester Hospital from the Great Village fire hall, but neither of them have given any statements or interviews. Why?

There are over 400 pages of emails referred to in the foundational document between Ms. Banfield and the perpetrator. Why has only a small portion of these been released? Of those that have been released, they raise more questions than answers.

In her affidavit under threat of perjury and potential jail time, Cst. Vicki Colford swore that she does not recall having a conversation with Katy MacDonald about the Blueberry Field Road. Additionally, she swore the first time she recalls seeing a map with the Blueberry Field Road on it was days later at an RCMP conference. So how is her recollection so different from the radio transcripts? And has this been inquired into more by the Mass Casualty Commission?

The photo that Nick Dorrington had of the perpetrator's licence from when he pulled him over was being sent out to members upon request. Why wasn't it sent out to everybody immediately? Why did Dorrington not send this to the command centre?

In Comm 0038932 S/Sgt. Vickers, who to my understanding was at

the time the head of the MCU, has three separate entries into his notebook for Cobequid Court. At 4:48 on the 19th he has an entry for:

> "1. 46 Cobequid Court with two deceased males at the entry.
> "2. 41 Cobequid Court for a deceased male and one female."

And a separate entry for 45 Cobequid Court with three more bodies. There is no RCMP or MCC interview with him and no member report for him. What does he mean that there are three more bodies at 45 Cobequid Court? Has the MCC followed up on this?

This is further validated in Chief Superintendent Janis Gray's notes. She attached CROPS officer Chief Superintendent Leather Comm 0051382. She has an entry on page 6 of her notes for 41 Cobequid Court with two victims, a female and a male; 46 Cobequid Court with one male. And subsequently at 6:40 two hours after the bodies were discovered on page 7 of her notes she has another entry for 45 Cobequid Court with possibly another three bodies.

Underneath this entry it appears she has a subsection listing three RCMP regimental numbers which are 56169, which is Chad Morrison; 45161 which is Heidi Stevenson; and 44900 which is Inspector Daniel Ulmer. Why has she written this in her notebook? And has this been followed up on by the MCC? Why has Janis Gray not given testimony in front of the MCC? This leads me to the issues management team and H- Strong 2.

Comm 0018505, the forensic report on page 7, Crime Scene Reports, states:

> "Forensic identification services investigator Sgt. McKenna gains entry to the secured property at 45 Cobequid Court. The previous day he had gone to 41 and 46 Cobequid Court. 45 sits in between these

residences." (As read)

Why does Sgt. McKenna return to 45 Cobequid Court when it isn't a crime scene?

According to Janis Gray Comm 0059587 on page 5 of the interview with the MCC John Robin was the liaison for H-Strong and IMT after Gray. On page 66 Janis Gray says that John Robin was the head of the IMT and that his role in the inquiry was being responsible for preparing documents and reports that would be given to the MCC. He also decides what to share with them in addition to reporting back to the CNIP in Ottawa and Deputy Commissioner Brian Brennan, CNIP at the RCMP.

Mike Butcher was an RCMP disclosure analyst and John Robin, who was head of H-Strong IMT as well as overseeing disclosure to the RCMP internal HOIT Investigation, the external ESDC Labour Investigation, and to the MCC.

In Tim Mills MCC testimony, he says, referring to the appointment of these two husbands of the Nova Scotia senior officers:

> "That's not incompetence, putting them on the Issues Management Team. You can't be that stupid. That's cover up. You can't be that stupid. That's coverup. That's corruption. There's no two ways about it." (As read).

This, in addition to his MCC statement:

> "That's not even stupid; that's just corrupt. And I'm not talking money corruption. I'm talking power corruption. I've seen it, two sets of standards, you know? We'll investigate the general duty members or, you know, the rank and file. You're not touching an officer, commissioned officer. We're protected." (As read).

What exactly was H-Strong to IMT? What was their purpose? And

most importantly, did their roles of disclosure liaison hinder or interfere with the MCC's mandate?

Justice Cromwell has written many letters regarding the DOJ not being forthcoming with documents. How much more information are not they not sharing with us. Why is the DOJ hiding so much from the families and the Canadian public?

On March 17th, 2021, the MCC and the DOJ entered into a clawback agreement. What are the details of this agreement? Why aren't they public? How does this impact the MCC and their work, and does this seem like transparency?

Chief Supt. Leather says that the DOJ told him to be reactive instead of proactive when talking about certain information. Is this standard practice? How many other witnesses were told this? How much information are we not being given because of this?

There is no doubt that Heidi Stevenson was a hero, a real hero, and the kind of person who should be an RCMP officer. There is no question about that. But the RCMP had a parade for her on Monday, April the 20th when my family was still laying dead in their house. Does that seem inappropriate to anybody else?

Before this happened, I loved the RCMP. I took my daughter to see them when I saw them there and I told her they were the real superheroes. "If you need help, that's where you go. You find a cop, RCMP specifically." And now we're terrified of them. I see them, I cry. My daughter thinks they're going to kill her. I didn't teach her this.

I struggle with a brain injury, which was in my previous thing but I wasn't allowed to talk about it, so that's why I struggle with reading all the documents that are available, and I've read very few of them. I have been with a very dear friend and a group of people who've been here with me since the beginning. They spend countless hours every single day reading and comparing documents and using their little grey cells to help me understand what's going on. And some people have called

us conspiracy theorists but if there weren't so many gaping holes, inconsistencies, and conflict of interest in this story, we wouldn't have to speculate about what really happened.

Cst. Wiley rightly pointed out the other day that the transcripts are so disjointed and barely comprehensible that he hardly recognized his own statement, and statements from many important witnesses are not available at all. After more than two years and millions of dollars, there are still so many holes in this story and countless unanswered questions. How can any of us be expected to make recommendations when we don't even know what happened?

More importantly, how can the family begin to grieve when we don't know what happened to our loved ones? There's so much information hidden behind black ink and red tape that the job cannot be done. As far as I can tell, the Commission has failed in its mission to find out what happened. Where is all the dashcam video and audio footage? Why hasn't all the GPS data been disclosed?

During the MCC, we have been told that unmarked RCMP cars don't have a GPS. But if this is so, why does Sgt. Bernard's unmarked, baby-blue Taurus have a GPS? Where is Brown and Melanson's GPS? Why hasn't every single phone, personal and/or professional been run through Celebrite and this information being disclosed, whether they be RCMP member, witnesses, or victims?

If an independent commission exists, like a Royal Commission, where there appears to be less government interference, that's what we need. And if the behaviour of the RCMP during this ordeal is what we can expect if we face another crisis like this, we should think about replacing with local police.

Chief MacNeil is the kind of guy we can put our trust in. He's accountable and he's very connected to the community. The model he follows would serve Nova Scotia much better than what we have with the RCMP. Chief MacNeil was able to implement all the recommendations in his Truro Police Department that the RCMP didn't.

Recommendations are not going to be enough here. We have history of recommendations being made and nobody even reading them, never mind implementing them and using them on the job. So these mandates -- these should be mandates. They should not be recommendations. This stuff should be mandated if you want to work for the RCMP.

Within days of this tragedy, the government tried to use this horrific crime to help push the gun ban that they had wanted for years. This perpetrator had no legally-obtained guns. Criminals, by definition, don't case about the law, so a gun ban is only going to make law-abiding citizens more vulnerable to violent criminals. There are numerous lessons that have come from this loss of life and one of them is that the police don't always show up when you need them, especially in rural areas, so we must be able to protect ourselves. If Aaron had a gun that night, this tragedy might have stopped at his house and all these other people, I wouldn't know them.

And you people are amazing but I'd rather that I didn't have to know because of this.

Let's remember why we're here. Twenty-three (23) people were murdered and their families want to know what happened. Since the beginning, the families have asked for all 23 victims to be recognized by the government and they, the media, and the MCC all insist on saying 22. I bet that Kristen and Nick Beaton think their baby counts as a person.

In my opinion, the MCC has been derailed by various special interest groups, and though they have very valid concerns, I struggle to see the remotest connection to the events that took the lives of our loved ones. We have all patiently waited and listened to see when and how this process was going to provide us with answers, and we are still waiting. Time has run out. Thank you. God bless 23.

COMMISSIONER MacDONALD: Thank you, Ms. Long.

COMMISSIONER STANTON: So thank you, participants, and to your counsel for your submissions. We'll of course consider them carefully, as we

always do.

Tomorrow, we'll continue to hear submissions from participants, and we do welcome and encourage submissions from members of the public with your ideas for change. On our website, we invite everyone to submit recommendations you'd like us to consider. There's more information online, including a discussion guide to help have conversations with your networks and to share your suggestions for change by introducing issues analyzed by the Commission and asking questions to help you think about potential recommendations. We're accepting your suggestions for change until the end of the month.

So thanks everyone, and we'll see here tomorrow.

THE REGISTRAR: Thank you. The proceedings are adjourned until tomorrow, September the 21st, 2022, at 9:30 a.m.

--- Upon adjourning at 2:03 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