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

Mr. Jamie VanWart	Commission Counsel / Conseiller de la commission
Mr. Thomas Macdonald	Counsel / Conseiller
Ms. Jane Lenehan	Counsel / Conseillère
Mr. Stephen Topshee	Counsel / Conseiller
Ms. Linda Hupman	Counsel / Conseillère
Mr. Jamie Goodwin	Counsel / Conseiller

Table of Content / Table des matières

	PAGE
Submissions by Mr. Tom Macdonald	5
Submissions by Ms. Jane Lenehan	13
Submissions by Mr. Stephen Topshee	35
Submissions by Ms. Linda Hupman	42
Submissions by Mr. Jamie Goodwin	57

IV
Exhibit List / Liste des pièces

No	DESCRIPTION	PAGE
	513 documents	4

1 Truro, Nova Scotia
2 --- Upon commencing on Wednesday, September 21st, 2022, at 9:32 a.m.
3 **REGISTRAR DARLENE SUTHERLAND**: Good morning. The
4 proceedings of the Mass Casualty Commission are now in session with Commissioner
5 Michael MacDonald, Commissioner Leanne Fitch, and Commissioner Kim Stanton
6 presiding.
7 **COMMISSIONER FITCH:** Good morning. Bonjour et bienvenue.
8 Hello and welcome. We join you from Mi'kma'ki, the ancestral and unceded territory of
9 the Mi'kmaq.
10 Please join us in remembering those whose lives were taken, those
11 who were harmed, their families, including those here in Nova Scotia, across Canada,
12 and in the United States, and all others affected by the April 2020 mass casualty in
13 Nova Scotia.
14 Today participant counsel will share more final oral submissions.
15 We'll hear from a number of different counsel representing family members, those most
16 affected, and some organizational participants.
17 Tom MacDonald will start, followed by Jane Lenehan, Linda
18 Hupman, and Steve Topshee, Jessica Zita, and Jamie Goodwin.
19 Before we hear from participant counsel, please know we will be
20 marking a number of documents as exhibits this week. Many of these are related to the
21 Commission's mandate on the causes, context, and circumstances of the mass
22 casualty.
23 These documents include RCMP training materials and information
24 about RCMP staffing in Nova Scotia. There are also some investigation supplementary
25 reports and interview transcripts that our team has completed, as well as documents
26 that have been referenced during proceedings and need to be entered as exhibits, and
27 a number of documents that have been recently received.
28 It is important that we have these documents on record to provide

1 context for the participants and public, and in order to inform out final report.
2 Commission counsel is working to tender as many of the
3 outstanding documents to be exhibited as possible throughout proceedings this week.
4 Given the time that it takes for the document production team to
5 move documents through the process, if there are documents remaining to be exhibited
6 after this week, the Commission will arrange a virtual proceeding in the coming weeks
7 for this purpose.
8 I will now call on Jamie Van Wart, Commission counsel, to exhibit
9 today's documents.
10 Mr. VanWart?
11 **MR. JAMIE VanWART**: Thank you, and good morning,
12 Commissioners.
13 So yes, I'd like to take this moment to tender a number of
14 documents and mark them as exhibits.
15 As indicated by Commissioner Fitch, as these hearings come to a
16 conclusion, the entire Commission team is working hard to ensure that all the relevant
17 documents are marked as exhibits.
18 We have been reviewing interviews, proceeding transcripts,
19 reports, to ensure that any referenced document is tendered as an exhibit. We have
20 also continued to receive new documents this month, and we have also continued to
21 conduct interviews this month, and certainly, the relevant documents we received this
22 month are being prepared to be marked as exhibits, and the interviews will be marked
23 as exhibits.
24 Today, we will be tendering of -- I'll be seeking to tender 513
25 documents. All of these documents have been shared with participants, as well as
26 Madam Registrar. They include RCMP organizational charts and legends, documents
27 from the Atlantic Policing Academy, and documents related to previous roundtables,
28 including Critical Incident Roundtable, Community Policing and Structure of Policing

1 Roundtable, and Police Oversight Roundtable.

2 There will also be a number of other relevant documents included
3 in the list that I am asking be tendered today.

4 I did want to draw particular attention to 25 documents. These are
5 all supplemental reports that have been completed by the Mass Casualty Commission
6 investigative team, and they are -- the purpose is to address any outstanding gaps in
7 the evidence that is before the Commission.

8 So I'll just kind of run through those. It'll take a minute, but I'll
9 identify the document and what they pertain to.

10 So there's COMM0015485. This is a supplemental report
11 pertaining to disciplinary decisions, the Denturist Society of Nova Scotia, and the
12 perpetrator's psychological visits.

13 COMM0053532, COMM0053534, COMM0053523,
14 COMM0053525, COMM0053341, COMM0053342, COMM0053343, COMM0053344,
15 COMM0053345, COMM005329, COMM0053347, COMM0053348, these are all
16 supplemental reports regarding drone footage, orthophoto mapping, video,
17 photographic and thermographic imaging pertaining to the Debert Business Park, Plains
18 Road, and Onslow.

19 COMM0056676 is a supplemental report relating to Max Liberatore.

20 COMM0058997 is a supplemental report relating to Cheryl Blakey's
21 last communication with the Tuck family.

22 COMM0054261 is a supplemental report relating to Bob
23 D'Entremont.

24 COMM0056190 is a supplemental report relating to the Wilson Gas
25 Bar timestamp and watermark instructions.

26 COMM0058517 is a supplemental report relating to J Division ERT
27 and ATAK.

28 COMM0058799 is a supplemental report relating to the Mass

1 Casualty Commission's attempt to contact Fitbit.
2 COMM0058988 is a supplemental report relating to Lisa Banfield's
3 phone records.
4 COMM0058996 is a supplemental report relating to Peter Griffin
5 and clarification of information on RCMP decaling.
6 COMM0059778 is a supplemental report relating to the availability
7 of non-RCMP air support resources on April 18 and 19, 2020.
8 COMM0061747 is an updated supplemental report relating to the
9 perpetrator's access to radios, use of knowledge of scanners, and that update was
10 completed on July 6, 2022.
11 And finally, COMM0063200 is a supplemental report that reviews
12 evidence regarding the questions relating to the idea that the perpetrator was a RCMP
13 confidential informant or agent.
14 So in total, as I've indicated, there's 513 documents. I'm going to
15 ask at this point if Madam Register could mark each of these documents as exhibits.
16 **REGISTRAR DARLENE SUTHERLAND**: So exhibited.
17 **--- EXHIBITS:**
18 513 Documents
19 **MR. JAMIE VanWART**: And finally, I wanted to make another
20 comment with regards to COMM number 0061298. This is a corrected version of a
21 foundational document. It was the foundational document of RCMP Command Post
22 Operational Communications Centre and Command Decisions, and this COMM number
23 -- the document associated is COMM number -- will replace COMM005771, which is
24 Exhibit P-001461. And the purpose for replacing this document is there was a
25 reference to a date of birth that should have been redacted but was missed, and so it's
26 replacing that and including that redaction.
27 Thank you, Commissioners, I will now step aside and -- for the
28 participants to make their submissions.

1 **COMMISSIONER MacDONALD:** Thank you, Mr. VanWart.
2 Mr. MacDonald.
3 **--- SUBMISSIONS BY MR. TOM MACDONALD:**
4 **MR. TOM MACDONALD:** Good morning, Commissioners. As you
5 know, I'm Tom MacDonald, counsel for Scott McLeod whose brother, Sean, was lost in
6 Wentworth on the 19th of April 2020.
7 The submissions, really, will cover a number of areas. The first will
8 be the procedural path, as we see it, to your recommendations, some discreet findings
9 of fact, recommendations themselves, implementation and oversight of those
10 recommendations, and a comment on the process and the report that will come.
11 In terms of the path, I mean it's self-evident to you as
12 Commissioners, but I think it ought to be noted because we're on the record, really, the
13 path starts with the Orders in Council, the two Orders in Council, the Government of
14 Canada's Order in Council, the Province of Nova Scotia's Order in Council, and that
15 sets out your mandate. I'm not, obviously, going to touch on every point in there, but
16 some of those highlights in those Orders in Council are for you to determine the causes
17 of what happened with this mass casualty, the police response, public communications
18 in terms of the police, mainly the RCMP but generally, and, of course, family support.
19 You have an evidentiary framework that this commission has put in
20 place to help you get to where you want to go in terms of formulating recommendations
21 and making findings of fact. You heard from many witnesses orally here, present in
22 various venues, virtually, by affidavit. There are thousands of documents that were
23 submitted. You heard from experts through roundtables, and you've heard from
24 participants, especially in one-to-one sessions, participant consultations. It seems self-
25 evident to say it but you just need to stick to your evidentiary framework and follow the
26 evidence. The evidence will give you the answers that you seek in terms of what
27 conclusions you should draw because the evidence, while not exhaustive, is voluminous
28 and it's bordering on exhaustive in terms of the number of evidentiary items that you've

1 heard, and seen, and read.

2 The findings of fact we've chosen to focus on are really five. One,
3 the beginning one is we would -- and all of this is said with respect. You will come to
4 your own findings of fact, but we submit, from the evidence that you have heard, there's
5 no other conclusion but there was confusion within the RCMP command structure in the
6 early hours in Portapique on the night of the 18th. It's clear from the policy of H-Division,
7 the risk manager was supposed to be in charge. We've heard these trite expressions,
8 "too many cooks in the kitchen," "all hands on deck". They were -- there were. It was
9 well-intended, but it was not following the policy. And I think the risk manager -- it was
10 difficult for him to do his job with all of the other hands helping. Well-intentioned but,
11 nonetheless, it wasn't the policy. So there was confusion in the command structure and
12 I think the evidence is before you that there was confusion.

13 Secondly is the containment issue. Again, well-intended but, at the
14 end of the day, an active shooter became a mobile active shooter. He left the
15 Portapique area and he transitioned to other areas of the province with resulting
16 fatalities. I think there's a finding, and you have the evidence before you, that there was
17 an issue with containment, the issue being lack of awareness of the local area. That's
18 the main issue. So on another day in another time, would the Blueberry Road have
19 been well-known to members familiar with the area? Maybe. We'll never know. But it
20 really is an issue in terms of that lack of knowledge.

21 The third finding of fact is the lack of awareness and use by the
22 RCMP of Alert Ready. We would submit, it is unacceptable. We've heard the
23 reasoning. I accept the reasoning, which was it wasn't in the playbook. But for the
24 National Police Force two years ago, in 2020, not to be aware is not acceptable at any
25 level. So it's not necessarily on the lower ranks. It runs through the ranks. And it was
26 not acceptable that there was this lack of awareness and use of Alert Ready.

27 Hand in hand with that is the delay in sending the tweet on the
28 morning of the 19th through the various levels of approval, and then the second-

1 guessing, if I can put it that way, of how approval was supposed to be reached. It
2 wasn't acceptable. Those layers of bureaucracy, or perceived bureaucracy, weren't
3 acceptable, and there was an unacceptable delay in sending the tweet.
4 The last finding of fact is sort of the one that has become more
5 prominent in recent weeks, and that's this allegation of political interference. I think that
6 you should strongly consider making a finding from the Commission's point of view in
7 terms of the evidence your heard as to whether there was or there was not. We would
8 submit, there was not in the traditional sense. I say that because Commissioner Lucki
9 gave evidence that she was the person, along with members of her senior management
10 team in Ottawa, who was in the meeting with the political people in Ottawa with the
11 ministers. She felt there was none. That's uncontradicted evidence. Why? Because
12 no one else who made these allegations that there was was in that meeting except her
13 and her senior team.
14 But there was a perception and an impression that there was
15 political interference and that's something that needs to be dispelled. It's not a good
16 look for the RCMP to have this sphere of -- in the air that there may have been political
17 interference, particularly when the senior command in Nova Scotia is of a contra view.
18 So I think, from the Commission's point of view, it is something worth addressing. It's
19 not the primary issue that will fall to you, but it is an issue.
20 In terms of recommendations, we really have 10 recommendations.
21 There are many, obviously, that you will look and would think it will -- your final report
22 will be more than -- much more than 10. But number one would be a clear, critical
23 incident command structure, especially with active shooters, and it needs to be
24 reinforced. Maybe the RCMP have done that now. We've heard, I think, that there are
25 two risk managers that may be assigned, but there needs to be clarity in these types of
26 incidents for the future in terms of what the command structure -- who is in command
27 when a critical incident begins and who is in command once the critical incident is
28 declared as such because we all know that if you have an active shooter, in those early

1 minutes, it's not declared a critical incident; it somewhere in the ether but it is a critical
2 incident, in effect, and so who's in charge? It's supposed to be the risk manager and
3 needs to be reinforced.
4 Training of awareness of local areas, rural areas, and that goes to
5 rural policing. There needs to be, and should be, this local awareness, which is taught
6 with the members, that if the RCMP are going to be doing rural policing in this province
7 there needs to be local awareness. Mr. Topshee made a very important point I
8 thought, back in his submissions; it may have been June, which was to liaise with local
9 volunteer fire chiefs, maybe lands and forest people, but there are people in – even if
10 it's a big geographical area like Colchester County who do know the local areas, and
11 they should be used as a resource and it should be sort of a first step when people
12 come into the area, RCMP members, to speak to the local people to know what the
13 local area and how to navigate it.
14 And that brings us to the third recommendation, which is a re-
15 imagination, if I can put it that way, by the RCMP of the rural policing policy, at least in
16 this province, maybe across the country.
17 We heard Commissioner Lucki say that it is an active issue for
18 discussion; it's really become an existential question in the sense that should the RCMP
19 be involved in rural policing anymore, at least in Nova Scotia.
20 And if the answer to that as determined by them and the province
21 of Nova Scotia is yes, then there needs to be a rethink. And we've heard about the
22 funding issues; I'm simplifying it, but the RCMP would say we don't have enough. The
23 province would say you have more than enough or sufficient. Whatever the funding is,
24 the RCMP needs to find a way to make the funding work if they're going to be in rural
25 policing in the province.
26 It needs to work for them so that the public is protected and so that
27 there is an absolute, clear importance to find rural policing policy in Nova Scotia.
28 Similarly with public communications, the use of alert ready and

1 twitter early in an active shooter critical incident. It looks like that happened and those
2 changes have been made from all of the evidence that you have heard, at least from the
3 Commissioner and others, and that the Critical Incident Commander now would seem to
4 have absolute authority to trigger alert ready and to direct that a tweet be issued.
5 Dedicated air support. I think it's time in this province if the RCMP
6 is going to be policing rural areas and now that Nova Scotia is a million people and the
7 areas of the RCMP will police, that there is available air support, whether it comes from
8 the RCMP resources, the provincial resources, it should be 24-7 air support availability,
9 with infrared capability not having to ask another province or region to use theirs, not
10 having to go to lands and forest, not having to wonder whether the helicopter is down
11 for maintenance; it needs to be fixed and fixed quickly because it is a safety net for
12 these types of incidents.
13 On the political interference issue, there should be a re-education, if
14 that's the word to use, of senior RCMP command so that everybody is reminded
15 respectfully where the line is in terms of political interference so that not only is it not
16 crossed, but that there is no room for a perception that there has been interference, if
17 there hasn't been.
18 Creation of a specialized family liaison officer unit with specific
19 training. For our province I'm not saying it needs to be a number of people, but there
20 needs to be specialized training so that that the unit is up and running and ready if there
21 is another critical incident that requires the intervention. With all the sensitivity that
22 comes with that type of a job I'm sure that the officers who dealt with that issue in this
23 mass casualty tried their best, but as you have heard and seen, it seems to break down
24 the middle. Some people were very satisfied, other people dissatisfied. So a
25 specialized unit may help to alleviate some of that.
26 We would submit there should be ongoing assistance for the
27 families who have suffered so much in the mass casualty. What does that assistance
28 look like? Well, it would be mental health assistance for sure. I'd leave it to you,

1 Commissioners, to define the period of time that this ongoing assistance should be
2 available but this can't be something that on March 31st of 2023 when your report is
3 delivered, that any assistance ends because the grieving continues and support is
4 needed beyond the filing date for the report.
5 The relationship between the RCMP and the Nova Scotia Police
6 Chief Association needs to be fixed. The Commission should address it. Maybe you
7 have a recommendation as to how it can be fixed, but talking to one another and
8 everyone being at the same table is a good start. And we've heard the RCMP seem to
9 be willing to do that with new people coming into the province, and I would hope that the
10 Police Chiefs Association would meet them half way so that that relationship can be
11 rekindled.
12 And the last recommendation would be the creation of an
13 implementation committee, and we've heard Ms. Miller suggest that yesterday. And I'll
14 speak a little more to that now and oversight.
15 So why an implementation committee? Well, really the first reason
16 is because things change, life changes, and so what do I mean by that? What I mean
17 is, two years from now you may have totally different leadership at the RCMP, a
18 different Minister of Public Safety, maybe a different government, different government
19 priorities, different funding priorities and this is too important to be left to the ups and
20 downs of change. So an implementation committee could survive the end of this
21 Commission and hold through recommendations or some type of oversight,
22 accountability on the parts of the main players.
23 In my view, that committee should be very small. It should
24 encompass without minimizing all of the interests that have been brought to this
25 Commission. And you've heard their evidence as we've gone through things; you'll
26 hear more in the latter days this week. Everybody's interest is important. The societal
27 interests represented by interest groups are important but in our view the main players
28 for an implementation committee are, of course, the Government of Canada, the

1 province of Nova Scotia, they're controlling the funding, the RCMP and someone to
2 speak for the families, almost like a public interest advocate, but it would be a family
3 representative. It could be someone nominated by the families, I leave it to you, but it
4 should be a small group so that it is not unwieldly. And I'm suggesting a second tier to
5 the implementation committee.

6 The second tier would be really the top tier, and that would be one
7 person, a decider, an implementation Czar, if you will. My suggestion would be a
8 Superior Court Judge, maybe someone who is still sitting who would be willing to be
9 seconded -- not for ever obviously, perhaps recently retired. But the importance of the
10 decider is this. What would they decide? What they would decide is, whether or not
11 your recommendations are being implemented at all, quickly enough, and taken
12 seriously and call it out if they're not, so that you have one person who is the -- the
13 implementation committee would speak to these issues, but it would funnel through this
14 one person who would then be the chief person who would decide whether it's being
15 implemented or not being implemented and call the government to account with respect
16 to that.

17 That kind of a framework also adds to transparency and I would
18 also recommend that your recommendations be prioritized. In other words, some of
19 your recommendations in my view should be ones that are red-flagged to be
20 implemented as soon as possible, some because they're just so important, and others
21 because maybe it's easier to get to certain things more quickly than others. So the
22 three that we would submit are the active shooter critical incident response in rural
23 areas, that's something that needs to be acted on immediately, if the RCMP is
24 continuing to police rural Nova Scotia.

25 The public communications issues with alert ready and the tweets,
26 should be dealt with immediately. It looks like maybe they have been.

27 And the last would be this family liaison specialized unit. I mean, is
28 it really that hard to specifically dedicate one or two officers at least in the beginning to

1 be trained and get them up and running to do that job?

2 There's another point I would make on oversight and really you can
3 only do so much as Commissioners. You'll have your recommendations; you'll have
4 your report. You will hope the government will implement all of the changes and then if
5 you recommend an implementation committee and a tsar, we'll see what happens. But
6 the important oversight is really the public -- the public in Nova Scotia, the public in
7 Canada through their elected representatives, and the media.

8 We see the media who are here. They've been here throughout.
9 Don't walk away after March 31st. Hold the government to account to implement these
10 recommendations, whatever they may be so that the 22 people whose names we see
11 every day won't be forgotten in terms of this and the expense, as we've heard --
12 whether it's $25 million or what the final amount is.

13 You said, Commissioner MacDonald, and the point stuck with me,
14 when Commissioner Lucki was here and also the Deputy Commissioner Brennan. You
15 asked for their commitment; I'm paraphrasing. And I take them at their word that they
16 would help because it's too important. The stakes have never been higher. And I
17 totally agree with you and to fulfill that commitment there has to be, in my view, this
18 public/media oversight as to whether these recommendations will be implemented.

19 In terms of the process in discussions with Mr. McLeod, I make
20 these comments mindful that not everybody sees this process in the same way, whether
21 as a participant or counsel. I respect everybody's point of view. Their story is their
22 story. This is Mr. McLeod's narrative and by extension, me as his counsel.

23 Mr. McLeod felt heard in particular in the one-on-one session. He
24 felt he's been treated fairly by the process. I would simply say as counsel in coming to
25 this, not from the beginning, when I had a question that I felt needed to be asked and
26 we couldn't agree in caucus, it was elevated to you, Commissioners and I was allowed
27 to ask it. If I had a question in caucus, I was allowed to ask it even if it wasn't through
28 my voice. If I submitted questions for other counsel to ask, they were asked. So within

1 this very different process -- because, as you know, I come from a civil litigation
2 background. It's adversarial. Cross-examination is expected. Within this process, this
3 trauma-informed process, which no one I think is suggesting is a perfect process, Mr.
4 McLeod feels that he was treated fairly and as his counsel, I feel I was treated fairly.
5 That's our narrative. It doesn't take away from anybody else's
6 narrative but I think it's important to make that point. At the end of the day, fairness may
7 be the best that anyone can ask for.
8 In terms of your report, I would only say one thing. I think that it
9 should be written in very plain language so that , yes, it's going to be a report that will
10 referred to for many many years. It will be read by academics. It will be read by
11 lawyers and judges and everybody else. But it's very important that anyone in the public
12 who chooses to read your report on March 31st or April 1st can, if asked the next day, at
13 least explain a little bit to their 10-year-old son or their 80-year old mother, "Well, what
14 did the Mass Casualty Commission decide?" So that they can not in a way of expecting
15 to know everything that was in the report, but the public will come away with an
16 understanding of what you did and what you found and what your recommendations
17 were.
18 The last point is really more of a personal one. I wanted to thank
19 counsel and all of the staff who were always very helpful with Mr. McLeod and myself
20 through thick and thin. It was much appreciated and sometimes it doesn't go
21 acknowledged but it should be acknowledged.
22 Subject to any questions, those are my submissions.
23 **COMMISSIONER MacDONALD:** Thank you very much, Mr.
24 MacDonald.
25 **MR. TOM MACDONALD:** Thank you.
26 **COMMISSIONER MacDONALD:** Ms. Lenehan?
27 **--- SUBMISSIONS BY MS. JANE LENEHAN:**
28 **MS. JANE LENEHAN:** Good morning, Commissioners.

1 My name is Jane Lenehan and along with my associate Dan White,
2 we represent the family of Gina Goulet.
3 Gina was the perpetrator's 22nd and final victim, murdered in her
4 home on Highway 224 on the morning of April 19. Gina's home was located just a few
5 kilometres south of the Shubenacadie Cloverleaf. On the morning of April 19, Gina was
6 home with her two dogs and she was texting back and forth with her daughter Amelia
7 and with a few of her friends and colleagues.
8 The perpetrator left the Shubenacadie Cloverleaf at about 10:55
9 a.m., right after he shot and wounded Cst. Morrison, shot and killed Cst. Heidi
10 Stevenson, his 20th murder victim, and shot and killed Joey Webber, his 21st murder
11 victim. And then he set fire to both Cst. Stevenson's cruiser and his own replica RCMP
12 cruiser.
13 The perpetrator then drove south on Highway 224 in the silver SUV
14 that he had just stolen from Joey Webber.
15 Based on the timing of Gina's last outgoing phone call to her
16 daughter, the best evidence we have is that Gina was murdered by the perpetrator at
17 about 10:58 a.m., shortly after he pulled into her long rural driveway, parked in her back
18 yard and shot his way into her home, wounding her dog Ginger in the process. Gina
19 died of multiple gunshot wounds inflicted on her by the perpetrator. And this murder
20 happened a full 13 hours, almost to the minute, after the perpetrator started his deadly
21 rampage some 73 kilometres away in Portapique.
22 The 73 kilometre estimate is based on the most efficient route from
23 Portapique through the province to Highway 224 but that's not the route the perpetrator
24 took. His actual route, the one that he traveled in his replica RCMP cruiser was much
25 longer than 73 kilometres, likely about twice as long.
26 Starting in Portapique the night of April 18, the perpetrator killed 13
27 people then drove to an overnight hiding spot in Debert where he continued his
28 rampage the next morning, driving through rural Nova Scotia and killing six more people

1 before he arrived at the Shubie Cloverleaf where he killed two more people, switched
2 vehicles, and then continued to Gina's home where he killed her.
3 We have learned that the perpetrator was able to travel undetected
4 along secondary roads, backtracking a number of times, and was able to drive straight
5 through the town of Truro unimpeded before he headed down Highway 2 first to the
6 Shubie Cloverleaf and then to Gina's house.
7 The focus of my submissions will be as follows: everything that led
8 up to Jamie Blair's gut-wrenching call to 9-1-1 on April 18, just after 10:00 p.m. and then
9 everything that happened in Portapique after that 9-1-1 call is relevant to the Goulet
10 family, all of those events, decisions, omissions, and mis-steps led to her murder.
11 However, my intention today is to focus primarily on events of April
12 19. The issues that are important to Gina Goulet's family, and the recommendations for
13 change that the Goulet family would like to see come out of this Inquiry.
14 The Goulet family fully endorses the excellent representations that
15 have been made and I'm sure will be made by my colleagues representing the families
16 who lost loved ones on April 18. But rather than repeat those representations, my
17 instructions are to focus today on why the rampage was not stopped before the April
18 19th murders happened.
19 Why was the perpetrator able to continue on and murder nine more
20 Nova Scotians the next morning, given all that was known to the police about the
21 perpetrator the night before?
22 And finally, I would like to set out the recommendations that the
23 Goulet family would urge the Commissioners to consider and adopt in the hope that
24 these recommendations will prevent a repeat of the tragic events of April 2020.
25 First, though, I'd like to just backtrack a little bit and talk about why
26 we're here. Why was this Mass Casualty Commission established jointly by the
27 Governments of Canada and Nova Scotia?
28 Please note that I am using the terms "Commission" and "Public

1 Inquiry" interchangeably.
2 By now, we're all very familiar with the Commission's mandate or
3 marching orders, as set out in the Orders in Council.
4 But in terms of why the Commission was established in the first
5 place, I'd like to refer the Commissioners to an article written by Heather Gardiner for
6 the November 30, 2009 issue of "The Canadian Lawyer".
7 In that article, Ms. Gardiner lists a number of recent examples of
8 investigative inquiries, including the Maher Arar Inquiry and wrongful conviction inquiries
9 such as the Donald Marshall Inquiry here in Nova Scotia and the David Milgaard
10 Inquiry.
11 And then she states:
12 "Common to all of these examples is that the
13 Canadian public did not trust ordinary government
14 institutions or processes to tell them how such
15 extraordinary events could happen. What went
16 wrong? Who was responsible? How can this be
17 avoided in the future? In each case a commission of
18 inquiry was established." (As read)
19 After explaining the unique role of public inquiries within the
20 Canadian Legal system, Ms. Gardiner goes on to state:
21 "Commissions of inquiry form a 'residual institution of
22 government' because they are established in
23 exceptional circumstances, when no other institution
24 or process of government appears to be adequate."
25 (As read)
26 She then goes on to quote from former Supreme Court of Canada
27 Justice Peter Cory in *Phillips v. Nova Scotia (Commission of Inquiry into the Westray
28 Mine Tragedy)*, and the quote in the paragraph I have given to Jenna Lee:

1 "One of the primary functions of public inquiries is
2 fact-finding. They are often convened, in the wake of
3 public shock, horror, disillusionment, or scepticism, in
4 order to uncover 'the truth'." (As read)
5 Justice Cory goes on to say:
6 "In times of public questioning, stress, and concern,
7 they provide the means for Canadians to be apprised
8 of the conditions pertaining to a worrisome community
9 problem and to be a part of the recommendations that
10 are aimed at resolving the problem." (As read)
11 Ms. Gardiner then states that the crucial purpose of public inquiries
12 is to restore public confidence.
13 She concludes her article with the following:
14 "Commissions of inquiry form a 'residual' institution in
15 the machinery of government that often serves a
16 unique blend of governmental, social, and political
17 purposes. They continue to be invoked when nothing
18 else seems adequate to satisfy public confidence and
19 there is no end in sight." (As read)
20 If we go back to those horrible events of April 18 and 19, 2020, and
21 then the weeks and the months that followed, I think it's fair to say that all Nova
22 Scotians and all Canadians were in a state of shock, horror, disbelief, and unbearable
23 sadness for those whose family members had been murdered. And then the questions
24 started. What happened? How did this happen here in rural Nova Scotia? Why did it
25 happen? Why wasn't the perpetrator stopped long before the Enfield Big Stop? Who or
26 what is responsible for this horrible tragedy?
27 For many families, including the Goulet family, the lack of answers
28 and lack of attention from the RCMP and from government agencies increased their

1 hurt and confusion, and led to anger, disillusionment, and a complete loss of trust in the
2 institutions that we count on to keep us safe, to guide us in times of loss and tragedy,
3 and to give us answers.
4 Most of us in Nova Scotia grew up with the vision and the mystique
5 of the red serge. The RCMP were seen as a comforting and reassuring presence that
6 we could count on to keep our communities safe.
7 Without in any way diminishing the dedication and the incredible
8 acts of bravery shown by individual RCMP members on the night of April 18th and the
9 morning of April 19th, and without engaging in Monday morning quarterbacking where
10 police actions and dynamic situations such as this are critiqued under a microscope and
11 with the benefit of hindsight, there is no question that for the families of the victims, and
12 for most Nova Scotians, that vision and mystique of the red serge, that comforting and
13 reassuring believe in the RCMP has been shattered.
14 The Goulet family believed that the only way they could begin to put
15 the pieces back together after April 19, to start to heal and move forward with their lives,
16 would be to find out what happened to Gina, why it happened, and what they could do
17 to help implement the necessary changes so that no other family would have to go
18 through what they have gone through and they're still going through.
19 But the RCMP weren’t talking, and seemed to the Goulet family to
20 be more concerned with closing ranks and protecting their own reputation than with
21 properly caring for the community they were supposed to be serving and protecting.
22 That is why the Goulet family first called for a public inquiry and then marched in
23 solidarity with the other victims' families to demand a public inquiry.
24 And that is why the Goulet family sat through all those days of
25 hearings both the working meetings in the fall of 2021 and then the presentation of the
26 foundational fact documents in the winter of 2022 with Gina's photo sitting on the table
27 in front of them, facing you Commissioners.
28 So at this point, I would like to just stop for a second and express

1 the gratitude of the Goulet family to the Commission for investigating so thoroughly and
2 for getting answers for them as to what happened on April 18 and 19 -- sorry -- and in
3 particular, what happened at Gina's house that morning, and also to express their
4 gratitude for exploring through what had been a very informative roundtables and expert
5 reports, why April 18 and 19 happened, and what we can do as a province and a
6 country to ensure it doesn't happen again.
7 Clearly, the mass murder that happened in Saskatchewan earlier
8 this month means that we have a lot to do still as a country.
9 These are the recommendations that the Goulet family would like to
10 see, and why.
11 First, the perpetrator's replica RCMP cruiser. We now know that
12 the impossible was indeed possible. Over a period of just seven months, starting in
13 March of 2019 and ending in April of -- or sorry, in October of 2019, the perpetrator was
14 able to purchase from GC Surplus four decommissioned RCMP cruisers. The total
15 amount he paid for those four decommissioned RCMP cruisers was only $21,596.81.
16 Intent on murdering and harming people, including members of the
17 RCMP, the perpetrator was able to purchase all that he needed to assemble his own
18 RCMP cruiser, and when complete, the perpetrator's RCMP cruiser was virtually
19 indistinguishable from a real cruiser.
20 This RCMP cruiser allowed the perpetrator to masquerade as a real
21 RCMP officer and thereby evade the RCMP as they tried to locate him on the night of
22 the 18th and again on the morning of the 19th.
23 The mass casualty was the most serious and deadly encounter
24 between the RCMP and the perpetrator when he was driving one of his
25 decommissioned RCMP cruisers, but it wasn't the only encounter. Just two months
26 before the mass casualty, the perpetrator had another encounter with RCMP in a
27 different decommissioned RCMP cruiser, not the replica one, but one of the three others
28 that he owned.

1 On the night of February 12, the perpetrator was observed Cst.
2 Dorrington on Highway 2. Cst. Dorrington was on duty that night heading east on
3 Highway 2, and the perpetrator passed him heading west.
4 The perpetrator was driving well over the posted speed limit. Cst.
5 Dorrington testified that he clocked him going 115 in a 70 or 80-kilometre mile zone --
6 sorry, kilometre-per-hour zone.
7 But Cst. Dorrington didn't immediately turn around and pursue the
8 perpetrator because he initially thought the vehicle he passed might have been, in his
9 words, "one of those RCMP traffic vehicles with subdued markings."
10 So instead, Cst. Dorrington took a moment to call dispatch to see if
11 one of their cars was in the area. After confirming it wasn't a real RCMP car, Cst.
12 Dorrington then turned around to pursue the perpetrator, pull him over, and give him a
13 ticket. I'm not suggesting any wrongdoing on the part of Cst. Dorrington. In fact, his
14 February 2020 encounter with the perpetrator later proved invaluable in piecing together
15 who the RCMP were dealing with on April 18 and 19.
16 But the problem is this. We've learned through the course of these
17 public inquiry hearings that there are three types of RCMP vehicles: unmarked
18 vehicles, marked vehicles such as the one the perpetrator was able to replicate, and
19 covertly marked vehicles, which the perpetrator was able to replicate with a
20 decommissioned RCMP cruiser the night of Feb. 12, 2020. We've learned -- so we've
21 learned that in the first four months of 2020, the perpetrator experienced some success
22 in impersonating an RCMP officer on two occasions using two of his four
23 decommissioned RCMP cruisers.
24 The question for the Goulet family is this. Is it worth the risk to the
25 safety of our communities for members of the general public to be able to buy
26 decommissioned RCMP cruisers for their own personal use? Should the RCMP, or GC
27 Surplus, or whichever configuration or conglomeration of federal government
28 departments and agencies is responsible for auctioning off RCMP cruisers to be

1 allowed to continue auctioning off these vehicles? The Goulet family submits that the
2 answer should be a resounding no.
3 What is the net financial gain to the Federal Government versus the
4 risk to the public -- to public safety in continuing to auction off these decommissioned
5 RCMP vehicle. The Goulet family submits that the net financial gain, which has not, to
6 the best of my knowledge, been calculated and disclosed by the Federal Government,
7 cannot be worth the risk to public safety that was so tragically demonstrated by the
8 perpetrator in April of 2020.
9 So the Goulet family's recommendation of the sale of
10 decommissioned police vehicles is this, that the temporary moratorium on selling
11 decommissioned RCMP cruisers, specifically marked RCMP cruisers and covertly
12 marked RCMP cruisers, become a permanent moratorium, and that the government --
13 the Federal Government be permitted to dispose of those vehicles by selling them for
14 scrap metal and parts, or destroying them, whichever makes the most economic sense.
15 So the second thing I want to talk about is Alert Ready and the
16 adequacy of the RCMP's warning to the public on April 18 and 19 of the danger facing
17 Nova Scotians.
18 At the conclusion of Phase I, I made submissions to you on behalf
19 of the Goulet family based on what we knew at that point. On the issue of public
20 alerting, I submitted that the citizens of Nova Scotia have a right to know if and when
21 they're in danger. The RCMP withheld critical information from Nova Scotians on April
22 18 and 19 and, as a result, the vast majority Nova Scotians were oblivious to the
23 seriousness of the threat posed by the perpetrator and the proximity of that threat.
24 On the morning of April 19, 2020, Amelia Butler was texting back
25 and for with her mother. They had both heard what was going on in Portapique. They
26 were both following social media. Gina reminded her daughter that she knew the
27 perpetrator, that he wanted her to work with him as a denturist, and, also, that the
28 perpetrator knew where she lived. At 10:00 a.m., Gina sent the following text to Amelia:

1 "It makes me nervous he's at large." (As read).
2 Amelia responded at 10:00 a.m. with two texts to her mother to
3 reassure her. In her first text, Amelia said:
4 "You will be fine where you are at. There's no way he
5 could get that far without being caught." (As read).
6 In her second text sent immediately after and still showing at 10:00
7 a.m., Amelia said:
8 "He would have to get across the river somehow."
(As
9 read).
10 Gina responded at 10:01 saying:
11 "Not sure if he's on foot or in car -- several victims."
12 (As read).
13 At 10:02, Gina texted the following to her daughter:
14 "They don't know if he's still in the area," most likely
15 referring to Portapique, "has been a loose cannon
16 since last night." (As read).
17 When Amelia said he would have to get across the river, she was,
18 of course, referring to the Shubenacadie River. You have to cross a bridge on Highway
19 2 to get across the Shubie River before you get to Gina's former home on Highway 224.
20 That bridge is just north of the Shubie Cloverleaf and just a few kilometres north of
21 Gina's former home. It would have been an excellent for a roadblock or containment.
22 At 10 o'clock, when Amelia sent her texts, the most recent RCMP
23 tweet and Facebook post was the post -- the Facebook post at 9:12 a.m. At that point,
24 The RCMP were still telling us that they were responding to a firearms complaint in the
25 Portapique area, that it was an active shooter situation. They name the suspect, said
26 there were several victims, and that the suspect was considered armed and dangerous.
27 Residents in the area were told to stay inside and lock their doors. If they saw him, they
28 were to call 9-1-1 and not to approach him.

1 The RCMP did not tell us that the perpetrator owned and was likely
2 driving a fully-marked replica RCMP car with a large antenna on the back, a call sign of
3 28B11, and a push bar, and that he might be wearing an RCMP uniform, although they
4 knew all of that critical information by 7:27 a.m. on April 19.
5 By the time of that 9:12 a.m. Facebook post, the information
6 coming from the RCMP to the public certainly made it appear to Nova Scotians that the
7 firearms complaint and the active shooter situation was contained in the Portapique
8 area. This was despite the fact that by 9:12 a.m. the RCMP had every reason to
9 believe, or at least strongly suspect, that the perpetrator had eluded them and left the
10 Portapique area some time ago. He was still at large, had not been located in the very
11 small community of Portapique, and Lisa Banfield said she believed he was headed to
12 Dartmouth in his fully-marked RCMP cruiser to target her family.
13 The Goulet family acknowledges and appreciates that H-Division,
14 and RCMP, and the Nova Scotia EMO signed a memorandum of understanding on April
15 30, 2021, a year after the mass casualty, that now permits the RCMP to issue alerts
16 without involving the NSEMO. The RCMP response to the June 2, 2022,
17 subpoena for written evidence certainly indicates that lessons have been learned about
18 the need to communicate with the public in a timely manner about threats and dangers
19 to our personal safety. Further, the RCMP seems to have accepted that the use of Alert
20 Ready in addition to social media posts is an effective way to reach the public,
21 hopefully, to warn the public but, as well, to make it possible for the public to report
22 sightings or other information that might assist the police.
23 Further, there appears to be an understanding that it is critical to let
24 the public know what the police know when they know it and then update the police as
25 more information comes in and the situation evolves. It certainly appears from the
26 media reports that the RCMP communications to the public during the recent
27 Saskatchewan mass murders were much improved, both in timeliness and content,
28 from what the RCMP communications to us during the mass casualty in April 2020

1 were, but I would submit that there remain concerns that the police, and not just the
2 RCMP but all police, will hesitate in issuing an alert to warn the public because of police
3 fears that a mass public warning will result in a flood of 9-1-1 calls that will overwhelm
4 the 9-1-1 system and create chaos, that the alert may provoke vigilante justice by
5 citizens in response to the warning, or a whole host of other reasons that seem most
6 likely to be related -- or rooted, rather, in police distrust of the community they serve;
7 "It's police business. The public doesn't need to know until we have it dealt with," et
8 cetera.
9 As an example of this concern, Chief Kinsella of the Halifax
10 Regional Police, testified at the Mass Casualty Commission on August 25 that unlike
11 the RCMP in April of 2020, it was inconceivable that HRP would not consider the use of
12 Alert Ready to warn the public in the event of an active shooter situation. Yet, just days
13 following Chief Kinsella's testimony before this Commission, there was a serious
14 weapons incident in Dartmouth on August 28, 2022.
15 HRP were called to a weapons' complaint because a man with a
16 firearm had barricaded himself inside a house. When the police attempted to arrest the
17 man, he confronted them with a gun outside the house. The man was shot and killed by
18 police. No alert went out to warn the community in Dartmouth that they were in danger
19 and should shelter in place or evacuate or stay away from the area until police had
20 cleared the area.
21 The Goulet family submits that the comments of HRP Inspector
22 Greg Robertson in his briefing note of April 27th, 2020, just a week after the mass
23 casualty, to HRP Kinsella and RCMP Chief Superintendent Gray where he was
24 reporting on the incident on April 24th, 2020 and the use of alert.
25 This is what he says in that briefing note: "As per call volume, really
26 it's impossible to say as we had a high volume for a fair bit of the afternoon due to…"
27 and then he goes on to explain call-outs for four or five different weapons' complaints
28 that afternoon.

1 So basically there were weapons calls in multiple areas given the
2 time of only a week after the Portapique and surrounding areas call, and the heightened
3 sense of vulnerability that the public is feeling on top of the pandemic, anxiety.
4 So in one sense the alert clarified what was actually going on and
5 where. I think, however, this would be an opportunity to educate both us, HRP and
6 RCMP, and EMO, and the public on what information will be in these alerts in the future,
7 the purpose of them being to warn of potential danger and to actually read the message
8 and not call 9-1-1 unless required.
9 I think honestly being the first one sent, it's a learning process for
10 everyone. I think the education piece, combined with a specific location area in future
11 alerts, as well as something in the alert to advise not to call 9-1-1 unless X, Y, Z, would
12 prevent a surge in calls and address the concerns over an increase in call volume
13 overall in the future.
14 And then he goes on to say: "I realize the alert may tax us
15 operationally for a short time, but if we do have an active shooter, the ensuing results
16 could be far more taxing. In a real situation an alert may save a life".
17 So the recommendation on the use of alert ready that the Goulet
18 family would ask the Commissioners to consider making, is as follows:
19 That all police forces serving the citizens of Nova Scotia, work
20 together cooperatively with the Nova Scotia EMO to develop: 1) a standard protocol for
21 the use of alert; 2) an education program for all Nova Scotia police forces that
22 specifically addresses their hesitation -- meaning the police as hesitation -- and their
23 concern about the use of alert ready; and equally important, educate our police forces
24 on their duty to warn the citizens they serve of impending danger; and an education
25 program for distribution to Nova Scotians as to what is expected of us when an alert is
26 issued and how we should respond.
27 This work should be overseen and subject to the approval of the
28 Public Safety Division of the Nova Scotia Department of Justice who will ensure

1 consultation with our communities.
2 The protocol for the use of alert ready in Nova Scotia should
3 include direction that all alert ready messages are simultaneously posted on social
4 media sites such as twitter and Facebook.
5 The next thing I want to talk about is the relationship between the
6 RCMP and the municipal forces in Nova Scotia. As one of my colleagues summed it
7 up, we don’t care who started it. It’s been astounding to learn that this petty feud
8 between the RCMP and municipal forces, who does what better, who’s trained better,
9 who’s better resourced, may have had tragic consequences for Nova Scotians on April
10 18 and 19. And it’s been disheartening to say the least, to learn during these inquiry
11 hearings that the poor relationship between the RCMP and municipal forces has
12 actually gotten worse, not better, since April of 2022 as our police forces continue to
13 point the finger at one another. There is far too much at stake in terms of public safety
14 for all of our police forces in this province not to resolve their differences immediately
15 and learn to work effectively together. This should not be an option for the RCMP or for
16 municipal forces. This should be a priority, if not “the” priority for police reform in Nova
17 Scotia and Canada.
18 Our police are public servants, their job is to serve and protect the
19 public and while many, many of our police officers in this province did exactly that on
20 April 18 and 19, there were some pointed examples where the poor relationship
21 between police forces frustrated their ability to serve and protect us that day.
22 As the facts unfolded as to how the perpetrator was able to get as
23 far as he did on the morning of April 19, my clients were very upset to learn about two
24 specific incidents between the RCMP and municipal police that changed the outcome of
25 April 19 had the relationships between our police forces been better.
26 First, there was an important email exchange between the RCMP
27 and Truro Police Service on the morning of April 19, specifically between Truro Police
28 Chief Dave MacNeil and RCMP Chief Superintendent Chris Leather. During his

1 testimony before this Commission on July 28th, Chief Superintendent Leather
2 acknowledged during his cross-examination by participant counsel, Mr. Scott, that he
3 received an email from Chief MacNeil somewhere around eight in the morning offering
4 to provide assistance if needed.
5 Chief Superintendent Leather agreed that he responded
6 approximately two hours later. The email in question was sent by Chief Superintendent
7 Leather at 10:00 a.m. In that email – and he copied Assistant Commissioner
8 Bergerman. He said "Thanks Dave; sounds like we may have the suspect pinned down
9 in Wentworth; we'll be in touch." Two minutes later at 10:02 Chief MacNeil replies,
10 copying assistant Commissioner Bergerman, "Thanks Chris; we can cover local calls if
11 the detachment members are tied up. Just ask. Take care."
12 Chief Superintendent Leather never does reply to Chief MacNeil,
13 nor does Assistant Commissioner Bergerman, and of course we all know that they didn't
14 have the suspect pinned down in Wentworth.
15 When asked about this by Mr. Scott on July 28th, Chief
16 Superintendent Leather testified that he knows now that the information he gave to
17 Chief MacNeil was incorrect. The suspect was not pinned down.
18 Chief Superintendent Leather acknowledged that he didn't follow-
19 up with Chief MacNeil to correct the information because he was too busy. The Chief
20 Superintendent also made a point of testifying that Chief MacNeil would have known
21 that there were better people closer to the ground than Chief Superintendent Leather
22 that Chief MacNeil should have contacted. However, he didn't point that out to Chief
23 MacNeil. He didn't give a name and contact information of another RCMP command
24 person that Chief MacNeil should talk to instead. He just tells us that Chief MacNeil
25 should have known better than to contact Chief Superintendent Leather.
26 So Chief MacNeil, the number one for Truro Police Service, offered
27 the assistance of Truro Police Service directly to Chief Superintendent Leather, the
28 CROPS officer in Nova Scotia, the number two for the RCMP in Nova Scotia, but he's

1 criticized by CROPS officer for contacting someone too high up in the RCMP chain of
2 command.
3 This type of bureaucratic response may make sense to the RCMP,
4 but with all due respect, it makes no sense to the victims' families and we're left to
5 conclude that Chief MacNeil made the offer to the RCMP, was told the threat was
6 contained and then never heard anything further.
7 This exchange was an important one to my clients as the
8 perpetrator was able to drive through the town of Truro, unimpeded, about 15 minutes
9 after that email exchange.
10 Between about 10:15 a.m. and 10:20 a.m. on April 19th, the
11 perpetrator drove through Truro and followed Willow Street out of Truro where it turns
12 into Highway 2 with the perpetrator passing the Millbrook RCMP Detachment at 10:23
13 a.m.
14 Had the RCMP and the Truro Police Service had a better working
15 relationship, it seems very plausible that the RCMP would have included Truro in
16 briefings of important information as this incident unfolded so that Truro Police could be
17 on the lookout for the perpetrator.
18 The fact that Chief MacNeil was not told specifically by the RCMP
19 that an RCMP cruiser had been seen by a witness, Mary-Ann Jay, at the scene of Lilian
20 Campbell's murder in Wentworth at about 9:35 that morning, and then that RCMP
21 cruiser headed south towards Truro, is inexcusable. And it left police in the dark about
22 the danger headed their way.
23 The second example has to do with Halifax Regional Police. Chief
24 Kinsella testified before this Inquiry on August 25. When I questioned Chief Kinsella I
25 explained to him that the Goulet family questions whether better relationships between
26 HRP and the RCMP and between Truro Police and the RCMP that would allow all of
27 Nova Scotia's police forces to work better together could have prevented the death of
28 Gina Goulet on April 19.

1 Chief Kinsella told me that he didn't have any specific knowledge
2 that would indicate that and he said, and I quote:
3 "The relationship piece is more in my view at the
4 higher strategic level. At the operational level I don't
5 think that the relationship would have affected
6 response or otherwise, as far as I know." (As read)
7 I then asked Chief Kinsella about an email from HRP ERT member
8 Brock Brooks to HRP ERT Sgt. Charles Naugle and HRP ERT member Jeff Carlisle,
9 dated April 27, 2020. In that email, Cst. Brooks identifies himself as the one watch ERT
10 team lead during the Mass Casualty. Cst. Brooks expresses the intense frustration of
11 the Halifax Regional Police ERT team that night, that they could not get permission from
12 management to call out more ERT members to assist.
13 Cst. Brooks says ERT knew shortly after midnight on April 19th that
14 this was "the biggest even in Nova Scotia history and that we should be staging in Truro
15 to assist."
16 Cst. Brooks reports that about 1:30 a.m. on April 19th after several
17 calls, Sgt. Robinson informed him that a decision -- and the entire ERT team -- that a
18 decision had been made by HRP management and no more ERT members were being
19 called out. He reported that the ERT members asked Sgt. Robinson if management
20 clearly understood what was happening.
21 Further on in his email Cst. Brooks reported that it seemed like to
22 ERT that management were just counting on the perpetrator being deceased at the
23 scene. However, they, being the ERT team, were listening to the Colchester radio often
24 and didn't hear anything indicating that the perpetrator was deceased.
25 It was very difficult for the Goulet family t process this email when I
26 shared it with them. An ERT team, which we have learned is key to an effective police
27 response to an active shooter situation, beaus they have the specialized skills,
28 resources, training, and experience -- an ERT team from a neighbouring jurisdiction

1 very close to Gina's home, in fact, wanted to help, wanted to stage in Truro to assist the
2 RCMP ERT team the night before Gina was murdered. But they can't get approval from
3 management to call out their highly trained members to assist in what became the worst
4 mass casualty in Canadian history.
5 The HRP ERT team knew what they needed to do to protect Nova
6 Scotians but their bosses wouldn't let them go. So clearly, the operational level is very
7 much impacted by the management squabbles.
8 And as one of my clients said in the Goulet family small group
9 session with you, the Commissioners, on August 30, she really hopes that in the future
10 that police forces in Nova Scotia can put their egos aside and do what needs to be done
11 to protect Nova Scotians.
12 So I have a recommendation for you to consider with respect to the
13 relationship problems between the RCMP and municipal police forces in Nova Scotia.
14 And in saying this, it's really just a first step but it may very well be a firm statement or
15 example to all police forces in Nova Scotia that Nova Scotians demand better from them
16 and demand change so that policing resources are used to keep our communities safe.
17 Recommend that Nova Scotia have one Emergency Response
18 Team with sufficient members or shifts or teams needed to effectively serve and protect
19 a province the geographical size of Nova Scotia with a population the size of Nova
20 Scotia. We understand that we have three. By all of the evidence that we've heard it
21 seems that three is more than enough.
22 Recommend that the Emergency Response Team be comprised of
23 equal members of RCMP members and municipal police officers.
24 Recommend that governance, leadership, or command and training
25 of this province wide ERT team rotate every five years between the RCMP and the
26 municipal police forces. So in Nova Scotia that would mean either HRP or Cape Breton
27 Regional Police, given that they're the only other two police forces in Nova Scotia who
28 have their own ERT team.

1 Air support. The lack of air support during the Mass Casualty was
2 canvassed thoroughly by my colleagues yesterday and the Goulet family supports those
3 submissions and the recommendations flowing from them. I have a few additional
4 comments.
5 First, we submit that during the Mass Casualty the lack of air
6 support was more about failures in communications than lack of resources and
7 availability of air support. We all know that Plan A was to call Moncton but that
8 helicopter was off duty sick. But we submit that ac component of Plan A was also for H
9 Division to immediately notify Deputy Commissioner Brennan of the active shooter
10 situation.
11 D/C Brennan testified before this Commission that in his role as
12 Deputy Commissioner in charge of contract policing he should have been notified of the
13 situation on the ground in Nova Scotia on April 18 as soon as possible so that he could
14 determine if H Division needed any additional services or equipment in order to properly
15 respond to the threat. D/C Brennan testified that he first learned of the active shooter
16 situation in Nova Scotia after Cst. Stevenson was killed, which was close to 11:00 a.m.
17 on the morning of April 19th. So he learned about it 13 hours later.
18 D/C Brenan should have been notified as soon as the critical
19 incident package was authorized the night of April 18 so that he could canvass whether
20 H Division needed additional resources. Plan A included notifying Deputy
21 Commissioner Brennan and that wasn't done. Plan B should also have been to notify
22 Deputy Commissioner Brennan.
23 We acknowledge that lessons have been learned by the RCMP on
24 this issue and changes have been made as a result. That seems evidence from the
25 RCMP H Division response to the June 2 subpoena for written evidence and from the
26 recent Saskatchewan tragedy.
27 The Goulets would like to suggest that the Commissioners consider
28 a recommendation that the lessons learned by the RCMP on the lack of air support

1 during the Mass Casualty and the changes made as a result be included in the
2 operational manual of the OCC as an air support checklist so that the next risk manager
3 or CIC, Critical Incident Commander, who is faced with a request for air support knows
4 exactly what to do and whom to contact.
5 Technology. The failure or inability of members to use pictometry
6 during the Mass Casualty event was also thoroughly canvassed by my colleagues
7 yesterday and by the Phase 2 excellent written submissions of the East Coast Prison
8 and Justice Society and the B.C. Civil Liberties Association. The only additional
9 recommendation that the Goulet family urges the Commissioners to make is that the
10 RCMP members should have 24/7 access to virtual IT or Information Technology
11 support.
12 Given the ability of IT professionals to work remotely and if
13 necessary gain access to and take control of members' computers, this does not need
14 to be a big ticket item in terms of cost. And in our submission, it would be enormously
15 valuable for RCMP members who are responding to stressful critical incidents and
16 experiencing difficulty and frustration in using the computer's programs available to
17 them to have an IT person to call and say, "Can you just work through this with me so I
18 can see if there are any routes out of Portapique?"
19 In addition, the use of IT professionals to guide and assist members
20 rather than focusing only on IT training for police could be part of the de-tasking
21 discussion, removing tasks from police that they're not ideally suited for or trained for,
22 and giving those tasks to others better suited to the tasks so police can focus on police
23 work.
24 Accountability. Mr. Bryson spoke yesterday about Sgt. O'Brien self-
25 reporting for duty shortly after. By his own admission, he had consumed about four or
26 five ounces of rum. Common sense tells us that was likely a conservative estimate on
27 Sgt. O'Brien's part.
28 I would submit that the only thing more shocking to Nova Scotians

1 than Sgt. O'Brien self-deploying that night is the RCMP's handling of that issue before
2 this Commission.
3 Sgt. O'Brien maintained in his testimony before this Commission
4 that despite the amount of alcohol he had consumed, he wasn't impaired, and the only
5 reason he had his wife drive him to the Bible Hill Detachment to pick up a police radio
6 was optics.
7 I agree with Mr. Bryson; it's just preposterous. Rather than simply
8 acknowledging at the outset that Sgt. O'Brien's behaviour that night was unacceptable
9 and had been dealt with by the RCMP, and ensuring Nova Scotians that they can and
10 should expect sobriety from RCMP members on duty, that evidence had to be drawn
11 out of RCMP management in cross-examination by Participants' counsel.
12 Chief Supt. Leather told us that he wasn't really aware of any of
13 those circumstances, but he conceded in his testimony on July 28 that members
14 consuming alcohol and reactivating themselves or going in for duty is not -- it's not just
15 ideal, it's not allowed by -- and the transcript says "policy", but I think it might be a typo, I
16 think -- or police -- I think it's policy.
17 But the exercise of pulling that information out of the RCMP in
18 these hearings has certainly left the impression that the rules don't apply to the RCMP,
19 and what we as civilians know -- don't know, won't hurt us.
20 It is difficult to articulate a recommendation in response to this
21 issue. The only thing that will suffice, I would submit, is meaningful civilian oversight of
22 policing in Nova Scotia.
23 The family liaison officer will have more to say about this in our
24 written submissions, and it has been covered by other counsel. We submit that this
25 issue relates to the problem of police officers taking on too many roles, many of which
26 they're not trained for or particularly well suited for.
27 The police aren't doing a good job with many of these roles, and it's
28 taking them away from the work they are trained to do. We've heard about the amount

1 of time -- police time spent in answering and processing mental health calls. Another
2 time-consuming task for police is arresting and detaining intoxicated individuals.
3 A recommendation that the Commission may wish to consider is
4 the creation, with direction of government, to create sobering centres paid for by the
5 Nova Scotia Liquor Commission so police do not have to use valuable police resources
6 to house intoxicated citizens overnight, and we do not continue to criminalize addiction
7 issues at unnecessary expense to our justice system.
8 My last point is police training and education, and again, we'll go
9 into this in more detail in our written submissions.
10 RCMP training, six months of Depot and six months on the job is
11 clearly not sufficient for today's world. Nurses have been considered a comparable
12 profession to police for pay equity discussions. Nurses are educated with a four-year
13 Bachelor of Nursing degree before they start their nursing career.
14 I concur with the many participant submissions that our police
15 officers need more education before we send them out to police in today's world. We
16 should follow Finland's example and develop a specialized university policing degree.
17 And this Commission should consider recommending standard education and training
18 for all police officers in Canada. That might be the only way to effectively address
19 RCMP culture and other ingrained issues such as discriminatory over-policing and
20 under-protection of our minority communities.
21 Those are my submissions, unless you have any questions.
22 **COMMISSIONER MacDONALD**: Thank you so much, Ms.
23 Lenehan.
24 We'll take a break now. Is it Mr. Topshee or Ms. Hupman who will -
25 - Mr. Topshee, you're next? Okay. We'll break for 15 minutes. Thank you.
26 **REGISTRAR DARLENE SUTHERLAND**: Thank you. The
27 proceedings are now on break and will resume in 15 minutes.
28 --- Upon recessing at 10:56 a.m.

1 --- Upon resuming at 11:14 a.m.
2 **REGISTRAR DARLENE SUTHERLAND**: Welcome back. The
3 proceedings are again in session.
4 **COMMISSIONER MacDONALD**: Thank you.
5 Mr. Topshee?
6 **--- SUBMISSIONS BY MR. STEPHEN TOPSHEE:**
7 **MR. STEPHEN TOPSHEE**: Good morning, Commissioners.
8 My name's Steve Topshee. I represent, with my colleagues at
9 Burchell MacDougall, Linda Hupman and James Russell. Together, we represent the
10 Tuck-Oliver families and the Lillian Campbell family.
11 Linda Hupman will address issues and aspects relating to the Tuck-
12 Oliver family. I will address issues relating to the Lillian Campbell family. Those
13 aspects are notification of next of kin, alert ready, roadblocks, checkpoints, air support,
14 and local knowledge in rural areas.
15 I will then address -- I will then turn to the RCMP contract policing
16 issue and the lack of transparency, accountability, and oversight, all of which we will
17 address more thoroughly in our written submissions.
18 Lillian Campbell was a resident of Wentworth, Nova Scotia, where
19 she lived with her husband, Michael Hyslop. They had one son, Chaz Hyslop. Her
20 professional career was first as a registered nurse, then finishing her career with the
21 Yukon Government Health Services.
22 The couple moved to the Wentworth Valley after retiring from their
23 jobs to enjoy their retirement years.
24 Lillian Campbell was murdered at the side of Highway 4 in
25 Wentworth at approximately 9:30 on Sunday, April 19th, 2020.
26 Earlier that morning, Lillian went for her daily walk sometime
27 between 9:02 and 9:12 a.m. Her husband, Michael, was expecting her back between
28 10:30 and 11:00 a.m., as she usually walked for one and a half to two hours per day.

1 She did not return.

2 Michael received a telephone call from his stepmother. His words
3 are as follows:

4 "My stepmother phoned me around 10:45 and asked
5 me if Lillian was with me. I said, 'No, she went for a
6 walk up the Valley Road.'
7 She told me she heard about some shootings out in
8 west Wentworth, and also about a woman being shot
9 in Wentworth, and that I should go get Lillian.
10 I left right away and drove from the house to the
11 junction of Highway 246 and Highway 4. There was a
12 large police presence there already, and Highway 4
13 was blocked. I never heard any sirens, had no idea
14 they were there.
15 I got out of my car, as I could see someone lying
16 under a blanket in front of Reg Jay's home, and I told
17 the RCMP officer I was looking for my wife, who went
18 for her walk and has not yet come back. He just told
19 me to get back in my car.
20 I told him again why I was there, and also told him
21 what she was wearing. He then told me to get back in
22 my car and someone would be with me shortly. I
23 waited for maybe 15 to 20 minutes in my car. Then, a
24 grey sedan with two officers came down Highway 4
25 from the West Wentworth direction. They went into
26 the blocked off area and I could see them talking to
27 others. They then drove up to my car and a female
28 told me my wife was deceased. I got out of my car,

1 tried to stand, but found it hard to do so. I remember
2 the officer asking if I had family or relatives close by. I
3 told her my step-mum was close. The two officers
4 drove me to my step-mum's, then departed. I
5 returned to home later in the afternoon.
6 Later on, the afternoon of the 19th, two RCMP
7 detectives came to my home and offered their
8 condolences, took down Lillian's personal information
9 and left. They mentioned that someone would be in
10 contact with us at some point in the future.
11 I received calls from Victim Services, also from
12 the RCMP Major Crime Unit, but was given little detail
13 on what actually happened, just to receive information
14 on support services that they provided me. The
15 majority of the information I received was from the
16 various media sources." (As read).
17 So notification of next-to-kin, as we just heard, Mr. Hyslop remained
18 in his vehicle for approximately 20 minutes alone, as he was directed. He was able to
19 see the body under the blanket. He did not know where his wife was. Imagine if this
20 was happening to you with your loved one. It was inhumane.
21 We're not saying the officers' actions were deliberate or planned,
22 but it appears that they no training or plan on how to deal with family in the aftermath of
23 such tragedy. Unfortunately, this pattern of behaviour repeated itself through the
24 tragedy. The next-of-kin notifications for Ms. Heather O'Brien and Ms. Kristen Beaton
25 come to mind. We ask the Commissioners to make recommendations regarding
26 protocol for proper next-of-kin notifications.
27 Alert Ready, the Alert Ready System -- Lillian left her home
28 between 9:02 and 9:12 a.m. on the 19th. She did not have her cell phone with her. She

1 was murdered some time around 9:30 a.m. In their home, the television was on, the
2 computer was open, and cell phones were turned on. Lillian and Michael were not
3 Twitter users. We do know that Twitter was the common -- was the communication
4 method used by the RCMP. We also know the RCMP was going to send out an Alert
5 Ready on the 19th. But before it could go out, the perpetrator was killed. That was
6 around 11:25, shortly after 11:25 a.m.
7 We acknowledge the efforts and steps that have been taken in the
8 past 28 months by the RCMP to set up policies and procedures and training for the use
9 of the Ready Alert as well as the system just used a short time ago in the horrific mass
10 casualty event in Saskatchewan. We suggest that the Commissioners make a
11 recommendation that the Federal Government be immediately tasked with
12 implementing a national public education program on public alerting in future alerts.
13 Roadblocks and checkpoints -- at one point during the early hours
14 of April 19th, it was surmised that the perpetrator may be headed to New Brunswick
15 where his parents lived. The RCMP directed an officer to the Cobequid Pass Toll
16 facility on the TransCanada Highway, Highway 104, which is one possible route from
17 Portapique to New Brunswick. A checkpoint was set up there between 12:03 a.m. and
18 9:45 a.m. The location of Lillian Campbell's murder was the old TransCanada Highway,
19 Highway 4. It is also a possible route to New Brunswick. The highway is well known by
20 locals and travellers. No checkpoints during those time periods, as I recall, were set up
21 on Highway 4.
22 Recommendation, from the Moncton Inquiry, 3.6 calls for a policy
23 and protocol through an emergency operational plan to identify entry/exit points and
24 major transportation that should be alerted and monitored in the event of a relevant
25 crisis. It appears the RCMP H-Division had this policy on the books but it was never
26 implemented on the 18th and 19th. Oversight is needed on this issue.
27 Air support -- it is perplexing and seriously concerning that this
28 tragedy -- while this tragedy was unfolding in Portapique, the RCMP in Nova Scotia

1 were unaware that the RCMP Air Support Services were not available. It was only at
2 approximately 11:16 p.m. on April 18th, 2020, that the RCMP Risk Manager, Brian Rehill
3 was informed there was no air support available.
4 And RCMP helicopter with the ability to fly at night equipped with
5 thermal imaging cameras could have been of great assistance in helping to locate the
6 perpetrator. General duty members called for air support, as noted in the foundational
7 document "Air Support":
8 "General Duty RCMP officers on the scene in
9 Portapique were also seeking air support services.
10 They sought the RCMP helicopters forward-looking
11 infrared capabilities as this would assist in locating the
12 perpetrator. Inquiries came in from responding
13 officers over the Colchester radio as early as 11:42
14 p.m. on the 18th, however, the members were told that
15 helicopters were not available." (As read).
16 Special Cst. Larry Labadie, the RCMP helicopter pilot from
17 Moncton, a pilot with 42 years of experience, gave a statement to the Commission. Cst
18 Labadie believed an RCMP aircraft would have given the RCMP a good chance to
19 catch the perpetrator because of the technical capabilities of the aircraft. Response
20 time from emergency calls to airborne aircraft, typically, is 45 minutes. Flight time from
21 Moncton to Portapique is approximately 45 minutes,) 112 kilometres or 60 nautical
22 miles' distance as the crow flies.
23 "If we had an aircraft available, I would have been
24 orbiting Portapique by approximately 00:30 on the
25 19th of April, and the weather and the environment
26 was very favourable for this mission request." (As
27 read).
28 There was no Plan B. Responding officers on all levels were

1 making inquiries as to the availability of air support. Throughout the night and into the
2 early morning of the 19th, phone calls and emails started in an attempt to locate and
3 secure air support. Calls and emails were made to the Joint Rescue Coordination
4 Centre, Search and Rescue, Transport Canada, the DNR, RCMP Services, Moncton,
5 and at 11:13 a.m. on April 19th, Commissioner -- Chief Supt. Chris Leather reached out
6 to Major Garret Holman of the Canadian Armed Forces. Major Holman indicated he
7 would quickly advance requests for any CAF resources.
8 As we know, a DNR Helicopter was located and then in the air of
9 the morning of the 19th for evacuation purposes. It could only fly in daylight hours and
10 at higher altitudes. It could not fly into hot zones. It was not equipped with FLIR and
11 had communication issues.
12 Valuable time and resources were used trying to secure air support.
13 These tasks likely factored into the communication delays as we've so often heard
14 about in the evidence and, unfortunately, contributed to tragic outcomes. It appears the
15 H-Division RCMP may have addressed the air support issues but we ask, again, that
16 this needs some oversight.
17 Local knowledge in rural areas -- there are many examples on the
18 18th and 19th where officers did not have local knowledge which, unfortunately, had a
19 negative impact on the outcomes. From the first responding officers, to the risk
20 manager, to the critical incident commanders, to the IRT team, many were from outside
21 Colchester County and few had a working knowledge of the road systems in the area.
22 Instead of calling the Truro Polices to assist, the RCMP called in officers from other
23 jurisdictions resulting in longer response times and having additional officers unfamiliar
24 with the area. This resulted in two officers becoming lost in the town of Truro and
25 requesting directions from the Truro police officers.
26 Another officer being assigned to the Onslow Belmont Firehall
27 Brigade, this officer did not know where the shooting was taking place and indicated he
28 was pretty confused on where the events were going on.

1 The perpetrator drove by this location; he drove past the firehall.
2 Command posts and comfort centres were set up in local firehalls. There were fire
3 chiefs, deputy fire chiefs as well as community residents there. These people had local
4 knowledge of the roads, the back roads, the people in the area; they were not called
5 upon.
6 Nova Scotia conservation officers Mike MacDonald and Dale
7 Cashin could have been called upon. They knew the geography of the county, the
8 communities, the roads and the back roads; they had mapping tools; they were
9 available 24-7. Going forward they should be used.
10 We say the Commissioners should make recommendations
11 regarding the usage of all available community resources, including conservation
12 officers, local fire services, municipal police, RCMP, EHS and all others in a critical
13 incident. Training of course has to be addressed. Finally, in relation to RCMP contract
14 policing, and the lack of accountability, transparency and oversight.
15 Across Canada there's a growing dissatisfaction with the RCMP
16 contract policing. In B.C., the special report of 2022, special committee report on
17 reforming the *Policing Act* recommends B.C. stop using the RCMP and create its own
18 police force. The Committee unanimously agreed a provincial force would create more
19 consistent standards for police response, training and oversight in B.C. across B.C.
20 The complete overall aims to ensure accountability, transparency and ensuring public
21 trust remains with policing.
22 The report indicates concerns with the current policing system such
23 as systemic racism, demand for accountability, concern regarding responses to mental
24 health and addiction calls, general lack of trust in how policing currently works. RCMP
25 has failed to effectively carry out their mandate providing for safety and well-being of
26 residents throughout the province, especially First Nations, inadequate RCMP oversight
27 and lack of resources.
28 Colchester and Cumberland Counties, Nova Scotia, have called for

1 reviews of the RCMP contract policing services. Colchester County has been
2 expressing concerns with RCMP staffing level and costs since 2015 and requested the
3 Truro Police Services provide a formalized proposal for police services in Colchester
4 County. That was prior to the mass casualty. Three other municipalities in Nova Scotia
5 have endorsed a review, HRM, Eskasoni and the Town of Wolfville.
6 Former Nova Scotia Justice Minister, Mark Furey, advocated for an
7 RCMP contract review in Nova Scotia before his tenure ended. We will be addressing
8 this more thoroughly in our written submission.
9 In summary, the recommendations coming out of the Portapique
10 Inquiry need to be implementable and actionable. They need to formalized and
11 progress-measured. The old days where we were rely upon a handshake or a change
12 of leadership are gone. Society is evolving at a rapid pace. Our national institutions are
13 not.
14 We encourage the committee to come up with recommendations
15 that include oversight to ensure the proper and timely implementation of the
16 recommendations, transparency -- and number two, transparency in the steps the
17 RCMP are taking in the implementation of the recommendations; and there needs to be
18 local accountability to build trust in our policing institution and ensure the safety of the
19 public and the police.
20 If the RCMP wants to stay in contract policing in Nova Scotia, they
21 must be motivated to change and not simply be posturing, otherwise the contracting
22 partners in Nova Scotia will move away from RCMP contract policing and towards
23 municipal policing and perhaps a provincial police force. Thank you.
24 **COMMISSIONER MacDONALD:** Thank you, Mr. Topshee.
25 **MR. STEPHEN TOPSHEE:** Ms. Hupman is going to speak on the
26 Tuck/Oliver issues.
27 **COMMISSIONER MacDONALD:** Thank you, Ms. Hupman?
28 **<u>--- SUBMISSIONS BY MS. LINDA HUPMAN:</u>**

1 **MS. LINDA HUPMAN:** Good morning, Commissioners.
2 So today I will use my share of our team's oral submission time to
3 focus on aspects of this mass casualty event and the inquiry that our particularly
4 germane to the members of the Oliver/Tuck family. This includes what happened to
5 their three family members, what issues have been of most concern for them during and
6 since the mass casualty, and I will comment on some areas identified for
7 recommendations going forward.
8 I will then address briefly, some more generalized and broader
9 issues of concern arising from the mass casualty in the course of this inquiry, a call-out
10 for recommendations pursuant to this Commission's mandate. Some of those I would
11 note have been addressed by previous submissions of our colleagues, but I will just
12 also just highlight without going into any detail.
13 These oral submissions and those of my colleague Mr. Topshee
14 are but an overview of what we plan to cover when we do our detailed final written
15 submissions. I will address the evidence of what happened on Cobequid Court. A few
16 brief comments on the evidentiary record and timeline applicable to the murders of our
17 clients' family members in their home on Cobequid Court on the night of April 18th,
18 2020.
19 There is no evidence before this Commission that allows for a
20 definitive conclusion as to the precise circumstances and timing of the deaths of Aaron
21 Tuck, Jolene Oliver and Emily Tuck.
22 In the course of this inquiry the Mass Casualty Commission
23 investigators have gathered evidence and supporting information for two reasonably
24 plausible hypothesis, and we would agree that the most likely of the two, is as set out in
25 the foundational document titled "Portapique – April 18-19th, 2020".
26 That most plausible hypothesis is that the perpetrator went to
27 Cobequid Court after leaving the Blair residence on Orchard Beach Drive at which time
28 he murdered Aaron Tuck, Jolene Oliver and Emily Tuck, as well as Joy and Peter Bond,

1 who also lived on Cobequid Court.

2 The belief is, that this likely occurred between 10:05 p.m. and 10:15
3 p.m. This accords with the information that Emily Tuck had been texting with a friend
4 that evening and was not heard from after 10:03 p.m., and also with the theory that the
5 perpetrator likely encountered Lisa McCully outside her residence between 10:13 and
6 10:15 as he travelled back up Orchard Beach Drive from Cobequid Court.

7 The alternative theory really is that it happened in the reverse
8 order. We will never know. Either scenario would result in a conclusion that their
9 deaths likely occurred between 10:05 p.m. and 10:20, taking into account more precise
10 timelines for the interactions of the perpetrator with other victims and at other locations
11 in Portapique after 10:20 p.m.

12 We would not take issue with the hypothesis that the perpetrator
13 likely left the community at about 10:45 p.m. by way of the Blueberry Field Road
14 immediately after the murder of Corrie Ellison at approximately 10:40 p.m. This theory
15 is supported as well by the video surveillance footage from Wilson Gas Stop in Great
16 Village depicting the replica police car passing by there, heading east at approximately
17 10:51 p.m.

18 So some of the key areas of concern for our Oliver Tuck family
19 clients. As would be expected after all of the evidence that has come forward, there are
20 many areas of concern but for the purpose of today's submissions I will focus on three
21 that impacted the Oliver Tuck family members significantly and then identify others that
22 we will address more fully in our written submissions.

23 The three areas I will focus on today are number 1, seeking
24 information about their missing family members. Throughout the day on Sunday, April
25 19th, the family sought information and experienced a lack of response to their queries
26 including a failure of the RCMP to discover the crime scenes on Cobequid Court for
27 almost 19 hours after they occurred.

28 Number 2, next of kin notification including difficulties with obtaining

1 timely and accurate information about their family members after they were discovered
2 and being actually informed that their family members were deceased, and what
3 happened to them from that point on.
4 And number 3, victim services. And under this heading we will
5 include the involvement and their involvement with he RCMP family liaison officer
6 contact.
7 So seeking information about their family members on Sunday April
8 19th, and I'm going to go into a bit of detail now. The members of the Tuck Oliver family
9 had a horrendous experience seeking information about their family members who lived
10 on Cobequid Court. And they deserve to have that emphasized here as the Inquiry
11 proceeding draws to a close.
12 As I outlined in the foundation document titled "Information seeking
13 from families and next of kin notifications" their ordeal began at approximately 7:00 a.m.
14 MST which was 10 a.m. here in Atlantic, when Bonnie Oliver placed a routine Sunday
15 morning call to her daughter Jolene's cell phone. There was no answer. When a
16 second call shortly after that was not answered. Mrs. Oliver assumed the family had
17 gone out and that Jolene was simply not able to take the call.
18 Then she turned on her television. She saw news reports of
19 shootings occurring in the community of Portapique, Nova Scotia. Mrs. Oliver along
20 with her daughters Crystal and Tammy immediately made multiple attempts to reach
21 Jolene, Aaron and Emily by phone and text with no results. Bonnie Oliver then placed a
22 call to the RCMP, not sure what number or area -- where she reached them but she
23 was told they were busy and to try calling the RCMP detachment in Bible Hill.
24 When she did that she received no further information but she left
25 her contact information and provided information about the family members that she
26 could not make contact with, including who they were, where they lived and those kinds
27 of details. By 11:00 a.m. Atlantic time, Bonnie Oliver was so distraught that Crystal and
28 Tammy took over the efforts to reach the RCMP.

1 In the early afternoon Emily's cousin Sarah began reaching out to
2 Emily's friends via her social media to see if anyone had news but they had no
3 information on the family. Throughout the afternoon the family members continued their
4 efforts to reach RCMP by calling 9-1-1, and later by calling one of the RCMP media
5 officers who they had seen giving an update on the news. They received an answer to
6 that call, gave their information, provided the personal identifying information for Aaron,
7 Jolene, and Emily.
8 We know from the foundational documents that at approximately
9 3:20 p.m. Cpl. Jarret MacDonald took over from Sgt. Andy O'Brien as scene security
10 commander in Portapique. His notes reveal that over the course of his shift the OCC
11 sent messages to the mobile work station in his car about multiple inquiries from people
12 worried about friends and relatives that they knew lived in the area. At least one of
13 these was noted to be a woman in Alberta looking for information about her sister who
14 lived on Cobequid Court.
15 Finally, at approximately 4:49 p.m. Cpl. MacDonald attended at the
16 Oliver Tuck and the Bond residences on Cobequid Court in response to these inquiries
17 and he discovered two deceased at each residence. It was not until additional
18 members who had the later task to go with him at approximately 5:30 p.m. or
19 thereabouts to canvass all the homes in the area that the body of Emily Tuck was also
20 discovered.
21 Between 4:02 p.m. and 6:30 p.m. an individual at the OCC sent
22 several emails to the Major Case Command Triangle relaying requests for information
23 about Jolene, Aaron, and Emily Tuck including requests from Bonnie Oliver, Jolene's
24 employer, the mother of a friend of Emily, a friend of Aaron, Crystal Mendiuk, Jolene's
25 sister. And then at 7:55 p.m. another email went to the Major Case Command Triangle
26 advising of an inquiry from Sarah Mendiuk to 9-1-1 seeking information about Jolene,
27 Emily, and Aaron. That was forwarded to Cst. Bent at 8:12 p.m..
28 We know from the sources used to compile the foundational

1 document that the search of all buildings on the roads in the community were completed
2 at approximately 8:35 p.m. and no other deceased aside from the discovery of the five
3 new victims on Cobequid Court were found.
4 I've taken the time to set out this detail to demonstrate that on this
5 issue -- that being the delay in responding to these reasonable and expected inquiries
6 about people living in the heart of the area where the Mass Casualty began -- fell
7 woefully short. It demonstrates that there were no pre-established protocols or
8 procedures existing to respond to this aspect o a Mass Casualty situation of any type,
9 that being the influx of calls from concerned loved ones for those family members or
10 friends that they may have had in harm's way, and they have not been able to make
11 contact with.
12 In today's world of rapid-fire news dissemination via all manner of
13 mediums and all the related tools that people use to share information electronically, it
14 has to be expected to happen and it has to be prepared to be dealt with. Law
15 enforcement agencies wherever they may be needed to be prepared to deal with influx
16 of calls about possible victims in a planned and organized manner and with people
17 dedicated to that task.
18 This issue of inquiries from families or friends of persons
19 unaccounted for who are seeking information on their loved ones when they are not
20 able to contact them, falls under several of their mandates to inquire into and make
21 recommendations including, one, the response of police specifically here the RCMP;
22 and two, steps taken to inform, support, and engage victims' families and affected
23 citizens.
24 To that end I refer to the participant consultation session on victim
25 advocacy organizations held on August 29th of 2022, and in particular the presentations
26 on behalf of the Toronto Police Service and the Peel Regional Police on their respective
27 units now in place to respond to a variety of areas of a mass casualty event, but in
28 particular to do the intake and follow-up on incoming inquiries about missing persons,

1 persons not accounted for, which friends and relatives have reason to believe may be in
2 the midst of the event that is occurring. Their model includes having people dedicated
3 to that task.
4 I believe the Toronto Police Service unit is called the Victim
5 Management Response, and the Peel Region unit, the Major Event Management Mass
6 Casualty Unit. The presentations of these initiatives indicated that both are works in
7 progress but they have established the framework for response including who does
8 what, when, and how. The information shared by those presenters who are Inspector
9 Thomas Warfield and Detective Cst. Helen Burton from the Peel Regional Police, and
10 Cst. Danielle Bottineau for Toronto Police Service was instructive of how taking the
11 initiative to be proactive and prepared for a worst case situations can and should be on
12 the radar for all policing agencies in this country, and not the least of which is the RCMP
13 in its role as both a national police force and a service provider of contract in Indigenous
14 policing across the country.
15 Of key interest in both these presentations was the existence of
16 personnel, in some cases civilians, to get dedicated to taking calls from people seeking
17 information on possible victims and standing up very early on in an event a 1-800
18 inquiry line for people to call into and provide the information on those who they are
19 seeking. They then have discussed their procedures and technology they have ready
20 now, and that they have people trained on to then take and match up the inquiries with
21 information that's been got from the scene.
22 This takes the load off the shoulders of those dealing with the
23 immediate response and establishes an organized and methodical process addressing
24 these inquiries from people, which are a natural and expected part of these events.
25 It does not appear from the presentations of these two examples of
26 Mass Casualty Event Management Units that it is necessary than have full-time
27 dedicated staff just for that, and that makes sense. Logistically, this could be units that
28 stand up when needed and are trained and tasked, ready to step into that role, but

1 when these kinds of events, since they are, we always hope, few and far between,
2 these people would have other functions, other jobs. But their role in such an event
3 would be to move into that unit.
4 I can only imagine how much easier things might have been for
5 Bonnie Oliver and her family members if there had been even a central 1-800 number to
6 call and make their inquiries, and to know that they could be actioned and tasked from
7 that point.
8 So in considering this area and the ordeal of our clients, we urge
9 this Commission to make a recommendation to address these concerns. Specifically,
10 we ask for a recommendation that the RCMP be directed to implement a Mass Casualty
11 Management Unit in each of its divisions across the country, modelled on those in place
12 now at Toronto Police Services and the Peel Regional Police, and to begin that process
13 not later than six months from the date of the recommendation, or such other timeline
14 that you, as the Commissioners, might consider reasonable.
15 We also invite the Commissioners to consider broadening that
16 recommendation to all police service provider agencies across the country take such
17 steps to implement such a unit, with the option for small and medium size police
18 services to enter into arrangements with larger police departments in their area, or the
19 RCMP provincial division in their locale to provide that specialized service when
20 needed.
21 The next key area is next of kin notifications. This is another area
22 that was dealt with in an inadequate manner as it related to the Oliver-Tuck family
23 members, and as you have already heard, for many other families as well.
24 The foundational document, "Information Seeking from Families
25 and Next of Kin Notification" notes that there are conflicting versions of how, by whom,
26 and when the Oliver-Tuck family members were informed officially by the RCMP of
27 confirmation of the death of Aaron Tuck, Jolene Oliver, and Emily Tuck. But it did occur
28 following long hours of trying to have police look into the situation involving their family

1 members.

2 Throughout the day, the family far away in Alberta were following
3 news updates, including changes to the number of victims, which at one point,
4 increased by three, being the same number of unaccounted for members of their family,
5 yet, it was considerable hours after that before they had confirmation of their deaths.

6 The details of the discrepancies between RCMP members' account
7 of when and to whom calls were made between approximately 8:38 p.m. and 11:30
8 p.m., Atlantic Standard Time, on April 19th are set out in paragraphs 165 and 170 of the
9 foundation document, "Dealing with Next of Kin Notifications". It is unlikely to be
10 resolved at this point, in terms of who called when and at what point.

11 But the key point is that between the time the deceased were first
12 found at the home at 4:49 p.m. and when confirmation was given to the family at either
13 10:15 p.m. or 11:30 p.m., distraught family members thousands of miles away were in
14 agony, wanting to know with certainty that their loved ones had been killed.

15 Considering they had been calling for many hours and had given
16 many different call takers detailed information on where their family lived, who lived
17 there, personal information that could be used to identify them, it still took five to six
18 torturous hours to receive the notification that they were seeking. We think that was too
19 long.

20 Yes, it was a horrific event on a huge scale, and police were coping
21 with an unimaginable situation. The victims and their families deserve to have better
22 and quicker attention to identifying victims and notifying next of kin.

23 So our recommendation in this regard is that the RCMP -- our
24 suggested recommendation is that the RCMP review and improve existing next of kin
25 notification protocols and specifically develop alternative protocols applicable to mass
26 casualty events where the normal next of kin process and protocols might unduly delay
27 notification of family members of a mass casualty event.

28 And that's particularly important, again, in today's world where

1 news and information from any number of sources gets disseminated so quickly, and it's
2 very important that people do not receive notifications second and third hand.
3 The third area of key concern is the family liaison officer and victim
4 services. In regards to the family liaison officer, our clients are highly positive in their
5 comments on the support and attention they received from the appointed family liaison
6 officer, Cst. Wayne Bent. Beginning in the very early days after and continuing
7 throughout, they were appreciative of his efforts, his diligence in trying to keep them
8 fully informed.
9 But we do find support through the evidence that came out during
10 the inquiry proceedings that suggest this was a mammoth task to assign to one person,
11 and that in fairness to the many families involved in this event, and to Cst. Bent, many
12 more liaison officers should have been appointed for this event.
13 Further, as the evidence has also shown, members like Cst. Bent,
14 tasked to take on that role, have not had the benefit of any formal training to carry out
15 that very important role.
16 On that point, I refer again to the Mass Casualty Units created in
17 Toronto -- or by the Toronto and Peel Police Services. I understand from those
18 presentations that family liaison persons or similar roles are assigned to those units,
19 and that they have in place training programs for that part of their Mass Casualty
20 Response Unit. In fact, they are currently training people in that role.
21 And again, these do not have to be people dedicated to that role as
22 their jobs. They can be -- have other functions and other positions, but be trained and
23 ready to be deployed in -- as their response to such events.
24 The RCMP should look into what is being done there and see if
25 they can develop family liaison training program without having to totally reinvent the
26 wheel.
27 To that end, we would suggest a recommendation that the RCMP
28 immediately identify existing members within each division to be designated and trained

1 as family liaison officers to be deployed when required on a case-by-case basis.
2 Victim services. Our clients availed themselves of a number of
3 services through the Nova Scotia Victim Services program. However, their location in
4 Alberta was significant and caused a number of issues for them which would not have
5 been the case or may not have -- especially would likely not have been the case for
6 those seeking the services here in Nova Scotia.
7 Contact -- initial contact with the family by the agency here in Nova
8 Scotia was reasonably prompt, at approximately four days post-event, but it would also
9 have been of assistance to have had a call in a shorter period of time.
10 It was difficult for our clients to get a clear picture of what was
11 available, how services could be accessed. How to deal with the paperwork and the
12 process to obtain counselling was also difficult and stressful for the family members.
13 When services were being accessed, the distance factor was still
14 an issue, for example, to obtain sufficient funding to cover counselling for family
15 members in Alberta, as the funding provided by Victim Services here was not sufficient
16 to meet the higher fees for those services in Alberta.
17 It worked out in the end with additional amounts being provided, but
18 it took a lot of back and forth, and the effort to navigate all of those issues added to the
19 stress and negative impact of the tragedy on the family that they were already
20 experiencing.
21 While many people at Victim Services were helpful on one level,
22 overall, it was very difficult to utilize and coordinate from afar.
23 Much of the sourcing of appropriate counsellors for this kind of
24 trauma situation fell to the family members in Alberta to seek out and find their own
25 sources. And as they were dealing Victim Services in Nova Scotia who didn't have a
26 full understanding of the information and knowledge of who and what areas of
27 counselling was available to refer them to in Alberta.
28 Had there been a procedure, perhaps, to transfer them to a similar

1 program or agency in Alberta, it likely would have taken a great deal of the stress and
2 anxiety off the family members who were trying to put together their own access to
3 services. It's not clear to us whether there exists an established means of transfer of
4 cases to other jurisdiction with billing back to the province of origin but, in the absence
5 of that, it would be an improvement and, we think, a practical recommendation to be
6 looked at and implemented if possible.
7 So our recommendation in that area would be that the Provincial
8 Government of Nova Scotia -- that we recommend that the Provincial Government of
9 Nova Scotia explore with other provinces exchange of service arrangements and
10 agreements to allow for transfer of cases where eligible recipients of the Victim Services
11 Program in any province who reside in another province can have their case file
12 transferred to their province of residence whose agency will then work with them to
13 arrange and coordinate the appropriate services for the situation with, likely, bill-back
14 arrangements to the province where their eligibility for services arose.
15 Now I will make some brief comments on other areas of concern
16 which are more broader than the specific ones. And, as I mentioned, some of these
17 areas have certainly been dealt with through some of the other presentations. And the
18 fact that we do not speak to these areas in depth here should not be taken in any way
19 as indicating a lesser importance, quite the opposite. These areas are of a more
20 general and broader nature in their impact on victim's families and others affected by
21 this tragedy and, today, we want to, for the most part, focus on the specific issues for
22 our clients.
23 The other topics of concern relating the event itself which will be
24 addressed in our written submissions in more detail, and which previous presenters
25 have addressed, include, in no particular order:
26 shortfalls in the immediate containment efforts in Portapique, that is
27 to say from the first moments of arrival to at least 30 to 40 minutes following that;
28 failures and breakdowns in the dissemination of firsthand witness

1 accounts of critical information, i.e., the name and description of the perpetrator, the
2 description of the vehicle he was driving;
3 failure to reach out to local residents or to acknowledge information
4 provided by those leaving the community that would have assisted the boots on the
5 ground to have greater situation awareness of the community including, potentially, the
6 Blueberry Field;
7 commanding control confusion throughout the event, and especially
8 in the first critical hours and, I would add to that as well, and echo the comments earlier
9 by other presenters about the -- that it was -- designating this as a critical incident could
10 have happened earlier and might have expedited some responses;
11 the inexcusably lengthy delay in releasing the information on the
12 perpetrator's use of a fully-marked police car and clothing known from the very first 9-1-
13 1 call and given by subsequent witnesses, being the Blair children and Andrew and
14 Kate MacDonald, all within the first 30 minutes of the event;
15 the failure to accept at face value and to act on the evidence early
16 on of the existence of a marked police car being used by the perpetrator and instead
17 making assumptions that the information had to mean something different because it
18 was simply too hard to believe even though it was coming from actual event;
19 communications, generally, and radio traffic overload;
20 containment, security, and control of crime scenes;
21 chronic understaffing of RCMP general duty members;
22 following the awareness of the shooting of Lillian Campbell in
23 Wentworth at approximately 9:30 on Sunday morning, the 19th, there was lack of any
24 meaningful containment measures by police, as addressed earlier by my colleague and
25 will be addressed further in our written submissions;
26 issues surrounding the illegal gun trade, specifically cross-border
27 smuggling of guns and the need for potential increased efforts to target smuggling from
28 the border perspective;

1 failure to appropriately engage neighbouring police agencies such
2 as Truro Police and the Halifax Regional Police;
3 the completely inadequate investigations years earlier in 2010,
4 2011, and 2013 of complaints and information connecting the perpetrator to firearms,
5 threats against relatives, and incidents of domestic violence, which now will always
6 leave questions of whether different actions then could have prevented what happened
7 in 2020;
8 this issue of the adequacy of the RCMP cadet training approach in
9 today's world of policing. Is the past practice of its traditional six-month basic training
10 model at Depot and six months' on-the-job training following that the best model going
11 forward or should it become a thing of the past? And here, we will make reference to
12 the Finnish approach in terms of the training in Finland;
13 the continued routine use of transfers of RCMP members,
14 particularly early in their career, to different postings and the negative -- and potentially
15 negative impacts of that in terms of, especially in the rural policing context, becoming
16 familiar and knowledgeable about the areas in which they are serving.
17 These are a sampling of the areas of concern that have been
18 addressed in various ways during the inquiry proceeding through foundational
19 documents, in-person testimony, roundtables, and other formats.
20 A brief comment on one of the Commission mandates, police
21 policies, procedures, and training in respect of active shooter incident, we would expand
22 on this in our written submission but, in brief, we will urge that there be
23 recommendations in the area of training and preparedness for active shooter event for
24 all police services that ensures they prepare and urge officers to, among other things,
25 always be prepared and willing to think outside the box.
26 Another recommendation we suggest that would be practical and
27 useful for the Commission to consider is that the mass casualty event of April 18th and
28 19th, 2020, be made a case study at the RCMP's Depot and all other police training

1 colleges and academies to add in training programs focused on active shooter
2 situations.
3 In closing, “lessons learned” is a phrase that has been heard
4 throughout the course of these proceedings. It appears many lessons may have
5 already and, hopefully, there are more to follow. But I suggest that one of the biggest
6 I’ve learned from this mass casualty is that no community in this country is too small,
7 too remote, too peaceful for another Portapique to happen. But we hope, and I believe
8 it is our clients’ hope, and other family groups as well -- and from both our family groups
9 -- and our hope, as their legal team throughout this journey, that the outcome of this
10 inquiry, the work of all of the participants, the Commission counsel, and you the
11 Commissioners, will be a report containing recommendations that will drastically reduce
12 the potential for these events to happen in the future.
13 I’d like to be optimistic enough to say “never happen again”. I don’t
14 think I’m there yet. And that may not be realistic, especially given the recent mass
15 casualty in Saskatchewan at the James Smith Cree Nation. Be we and our clients hope
16 that there will be lessons learned from the tragedy of April 18th and 19th, 2020, that
17 results of -- and efforts of this Commission will ensure that the lessons learned are
18 embraced by all of those who need to embrace them, they accept that those lessons
19 are valid and are necessary to learn and improve from, that everyone involved, police
20 and governments, makes their best efforts going forward to accept those lessons, that
21 they recognize and accept that there were shortfalls, that they accept and having a
22 willingness to correct mistakes and to be accountable when they should be so that in
23 the future, to the greatest extent humanly possible, such heinous actions can be
24 prevented. But if not prevented, that there is in place greater preparedness by our
25 policing services to respond quickly, effectively and as highly equipped and trained as
26 possible, with all the necessary tools and training to contain the threat and protect and
27 preserve innocent lives so a tragedy of this nature and scale does not happen again.
28 And that preparedness extends to all facets of the responding to

1 the mass casualty, whether it's police, victim services, all of these other issues that
2 have been identified. We hope that this is the legacy of this mass casualty commission
3 and through the result of its work, the legacy of those who lost their lives on April 18th
4 and 19th, 2020. Thank you.
5 **COMMISSIONER MacDONALD:** Thank you, Ms. Hupman. And
6 thank you everyone. I understand that there is a scheduling challenge for Ms. Jessica
7 Zita who was scheduled to appear next and will not be -- will be coming from outside the
8 province and will not be here until later today. So we propose to deal with that by
9 having her appear at 9:00 o'clock tomorrow morning which means we will be beginning
10 at nine tomorrow morning and we'll take lunch now, of course, but the next presenter
11 therefore would be Jamie Goodwin dealing with her clients, WSC, THANS and Be the
12 Peace. Thank you.
13 So we'll break until 1:30. Thank you.
14 **REGISTRAR DARLENE SUTHERLAND:** Thank you. The
15 proceedings are now on break and will resume at 1:30.
16 --- Upon recessing at 12:08 p.m.
17 --- Upon resuming at 1:33 p.m.
18 **REGISTRAR DARLENE SUTHERLAND:** Welcome back. The
19 proceedings are again in session.
20 **COMMISSIONER MacDONALD:** Welcome back everyone. Mr.
21 Goodwin?
22 **--- SUBMISSIONS BY MR. JAMIE GOODWIN:**
23 **MR. JAMIE GOODWIN:** Good afternoon Commissioners and
24 Commission counsel. My name is Jamie Goodwin and I am here on behalf of a
25 coalition consisting of Women Shelters Canada, the Transition House Association of
26 Nova Scotia and the Be the Peace Institute.
27 To begin, we acknowledge the suffering of the families and friends
28 of the victims in their quest or justice and accountability. Indeed it is what we all want,

1 try and unearth the answers to hard questions and compel significant change in our
2 systems. Our hearts go out to the families for their irreparable losses. We know this
3 has been an excruciating process for all of them. We also want to recognize the
4 devastating impact this has had on Lisa Banfield and her family. No person is an island
5 and no act of violence is an isolated incident. The events of April 18th and 19th are
6 inextricable from what led up to them, all the opportunities to flag, investigate and take
7 action to intervene and interrupt the cycles of violence.
8 Our focus and participation has been centered on intimate partner
9 violence. As we've heard in the research, it is a feature of almost every mass casualty
10 on record, a connection which begs us to take these dynamics more seriously from a
11 policing, criminal justice and community perspective. Many lives can be saved if we do.
12 These threads of the perpetrator's violence touch every part of the Commission's work.
13 We appreciate the opportunity through the Commission, to bring a focus to the history
14 and cycles of violence and to the failures to interrupt them.
15 This Commission has a gargantuan task. You must sift through
16 the facts and try to piece together how we are all supposed to move on. All of the worst
17 Canadian mass casualty events have been clearly connected to violence against
18 women. Does this prove causation? No. But the high co-relation in the form of red
19 flags and warning signs is essential to examine and consider in how policing and other
20 systems respond to the dangers posed by people who embody the course of controlling
21 behaviours of the perpetrator and who ignore -- who we ignore and overlook at our own
22 peril.
23 The Commission has an opportunity to refocus our national
24 attention on solving systemic and deeply rooted gender-based hate that fuels so much
25 violence in Canada.
26 We need to recognize gender-based violence and intimate partner
27 violence as a multi-causal epidemic that it is, one that requires a multi-system
28 government response working collaboratively with community-based agencies and

1 those most impacted by it.

2 We echo concerns of other counsel as to the inadequacy of the
3 RCMP response, the lack of preparedness to effectively manage this critical situation,
4 the obvious communication issues and the failure to fully investigate the complaints and
5 allegations of violence, abuse and illegal firearms. Thorough investigations could have
6 resulted in the perpetrator being stopped long before we got to April 2020.

7 Our coalition was disheartened by the apparent disinterest some
8 officers showed in reflecting on their past actions, whether other steps might have been
9 more appropriate or how other situations could be addressed differently in the future.

10 We were especially disappointed by the unprofessional and
11 sometimes patronizing disregard some officers have exhibited. These attitudes and the
12 lack of accountability on the part of the RCMP in general, does nothing to instill
13 confidence in the RCMP as an institution. Indeed this has exacerbated the loss of faith
14 and trust in this institution. It highlights the need for significant cultural change in
15 policing generally and the RCMP in particular.

16 There is a clear need for extensive education and basic training
17 that incorporates values, bias and trauma informed responses.

18 Our first request is that we call on the Commission to use its
19 platform to call out the false dichotomy between public and private violence. We cannot
20 make sense of the murders of April 2020 without understanding the perpetrators history
21 of family, gender-based and intimate partner violence. While some perceptions persist
22 that no relevant connection exists between that violence and the events of April 2020,
23 this is more a reflection of how we silo issues in an attempt to simplify them.

24 Violence in the home does not only harm the woman or partner
25 who experiences the physical or controlling abuse; that violence spills over to affect
26 others, often the children, and in this case, the broader community.

27 Children living in violent homes are subjected to physical abuse
28 themselves, but even when they’re not, they suffer harm from knowing about or

1 witnessing violence against their mothers. These experiences can work to normalize
2 violence against woman, setting some kids down the path to be abusers or victims in
3 the future.
4 Domestic violence pervaded the perpetrator's childhood and adult
5 life. He was a victim of violence and poverty and having been molded by that childhood
6 and adult life. He was a victim of violence and poverty and having been molded by that
7 violence, he became the monster who terrorized us in April of 2020.
8 He enacted violence against women in every aspect of his life. It
9 was part of who he was. It was well known that violence and poverty act like cycles,
10 trapping people as their victims until some of them emerge as the new abusers. We are
11 not suggesting that anyone should have sympathy or the perpetrator because of his
12 childhood. What we are saying is that if we do little to prevent or intervene when
13 children are victims of domestic violence in our society, one of the wealthiest societies
14 on earth, we should fully expect to create more victims and more perpetrators.
15 This leads me to the second area where we ask the Commission to
16 address in its report and recommendations. Children are not born misogynist. They are
17 not born racist and they're not born violent. These are all learned behaviours.
18 Given what we know about the epidemic of intimate partner
19 violence and the specific impact on children witnessing violence at home, we need to
20 prioritize early and ongoing education on this issue, and to counter the toxic aspects of
21 masculinity that can set the stage for future violence. While often community
22 organizations like my clients are called upon to go to schools and give talks about
23 intimate partner violence and gender-based violence, this is only a stop-gap measure,
24 More is needed. The curriculum taught to our children is devoid of meaningful
25 discussions about the pervasiveness of gender-based or intimate partner violence. It is
26 devoid of discussions about our emotions and healthy relationships.
27 Young boys are still too often raised to believe they need to
28 embody the masculine in all of their emotional responses. As the author Bell Hooks

1 puts it:

2 “There is only one emotion that patriarchy values
3 when expressed by men [and] that emotion is anger.
4 Real men get mad. And their mad-ness, no matter
5 how violent or violating, is deemed natural-- a positive
6 expression of patriarchal masculinity. Anger is the
7 best hiding place for anybody seeking to conceal pain
8 or anguish of spirit.”

9 Our children need to be taught that these issues exist. They need
10 to be taught that it is pervasive. Even if they are fortunate enough to have a violence--
11 free home they need to know that some of their classmates do not. They need to
12 understand that victims hide their bruises. They need to know that violence is never
13 acceptable and that they deserve better.

14 We ask the Commission to recommend that education regarding
15 intimate partner and gender-based violence be incorporated in school curricula
16 beginning at a young age and continuing all the way through high school. Children
17 need to understand that violence takes many forms. It is not just physical. They need
18 to understand the types of controlling behaviours that can be harnessed coercively and
19 instill great fear and dependency, including financial control, just as the perpetrator did
20 to his common-law partner.

21 Children and youth also need ready access to trauma-informed
22 mental health resources to help them comprehend and process the fear and confusion
23 of interpersonal violence without it dragging them into the cycle.

24 Autumn House in Amherst runs a program for the children of
25 violence to help them understand and grow and to prevent the cycle from pulling them
26 back in. These programs require sustained funding and they should be expanded.
27 These programs work and they will build a better future. They just need the
28 government’s support.

1 Third, women and abused partners know there are significant
2 consequences when leaving an abusive partner. They fear losing their children, their
3 home, their pets, their communities, and sometimes even their lives. Transition houses
4 of Nova Scotia and shelters across Canada assist victims in escaping places of abuse.
5 While the shelter system was first established in the 1970s and the 1980s, they
6 continue to play an essential role in providing victims a safe place to go when they are
7 ready to leave. They also play an important role in providing outreach services for
8 survivors in the community.
9 However, a one-size-fit-all response that is purely reactionary is
10 not enough. Since two thirds of survivors of domestic abuse will never report it to the
11 police, for all the harmful consequences I spoke of earlier, we need community-based
12 supports for victims. Community supports need to recognize the important distinction
13 between rural and urban contexts. In a rural community, affordable housing is often
14 even more scarce than in cities. Even if the victim finds a home, if she does not have
15 her own car she may nevertheless be trapped.
16 Gun ownership is much more common in rural settings which is
17 why one reason rural women are disproportionately the victims of femicide. We urge
18 you to recommend the government stop per capita funding when it comes to rural,
19 remote, and northern communities. These are the areas where the funding is needed
20 most.
21 Pro-charge and pro-prosecution policies were introduced with the
22 best of intentions but they've increasingly led to the criminalization of women and have
23 had a disproportionate impact on vulnerable communities.
24 I helped a woman who was less than half the body weight of her
25 partner, a uniformed employee of the federal government, when she was charged with
26 assaulting him after phoning the police looking for help. When the police arrived, he
27 said she had hit him first. Her job in the health care system required a clean record.
28 She almost lost her job because she asked for help.

1 Abusers know how to play the system just as the perpetrator did in
2 this case, and our law enforcement officials need to recognize that.
3 Alberta has introduced a safe at home program where the abuser is
4 voluntarily taken out of the family home, leaving the woman and her children in the
5 home as an alternative to forcing women to leave their familiar space. If you offer
6 people help, they will often take it. While not every violent man is going to volunteer for
7 treatment, a lot of them will and we will all be better off for providing these off- ramps
8 before the criminal justice system has to get involved.
9 Fourth, to stop the violence we need to shift the focus to the
10 abusers who are predominantly men. There are only a handful of programs in Nova
11 Scotia but they've had positive outcomes counselling violent men. If we want real
12 change, we need to build up these services and create a 24/7 crisis intervention model.
13 This will require a significant increase in funding.
14 But different approaches are needed to work with abusive men if
15 we want real changes and different outcomes. Transition houses and women's shelters
16 need to know the funding will still be there next year before they spend time, their finite
17 money and efforts, treating these men.
18 We would like serious consideration given to the idea that we need
19 shelters, 24/7 shelters, for the men who cause the harm to go where they can get
20 counselling and programming and the wrap-around supports that would help de-
21 escalate the risk of harm to their partner and their children. Not to take away from
22 women's shelters, as they are so vitally necessary, but to add to the efforts of
23 eradicating violence in homes. This will take courage and financial commitment but if
24 we are to look at making a real change, then doing things differently is necessary.
25 We also need laws like Bill C-21 to be enacted so that abusers who
26 are already known to the criminal justice system cannot access firearms. In a rural
27 context guns are a very common household tool. And we need laws to reflect just how
28 frequently they would be found in a home.

1 Fifth, we need to work with our Indigenous communities to help
2 create the programs needed to treat these issues. It is only made more complicated by
3 the intergenerational trauma that they have suffered as a result of residential schools
4 and other atrocities. Gender-based violence ad intimate partner violence do not exist in
5 a vacuum, and we must keep reminding ourselves of that.
6 Sixth, gender-based violence pervades all aspects of society and
7 no one community is immune. It cannot be siloed from other issues. That makes
8 gender-based violence far more complex in the African Nova Scotian community. It is
9 structurally difficult for a victim in that context to leave an abusive relationship because
10 of the historical oppression, discrimination, and unequal treatment of African Nova
11 Scotians.
12 Due to the difficult relationship this community has had with
13 policing, even bystanders who could report the violence are left worrying that involving a
14 predominantly white police force is only going to subject the perpetrator to racism or
15 worse. Further, studies have found that even when reported, violence against racialized
16 women is treated as less serious and less urgent in our criminal justice system. This
17 community needs funding to support its women, and what should be funded is not more
18 policing, but more community-led resources for those experiencing violence. There are
19 people who want to help, but they do not have the sustainable funding to do so.
20 And again, I highlight the need that these sorts of resources need
21 to be run and operated by members of the African Nova Scotian community so that
22 cultural sensitivity can be assured.
23 Seventh, while we recognize that there are flaws in the criminal
24 justice system, it is there as a last resort, and it will unfortunately, continue to be
25 needed.
26 With that in mind, our coalition would call for the federal
27 government to study the possibility and ramifications of including coercive control in the
28 Criminal Code of Canada.

We also ask that close attention should be paid to unintended consequences of criminalizing any behaviour. Abuse need not be physical. Financial or emotional domination, manipulation, and gaslighting can be just as harmful to the victims and has serious long-term impacts and health consequences.

As explained in the foundational documents tendered during Phase 2, coercive control refers to a course of intimidating, degrading, and regulatory practices by abusers to manipulate, intimidate, instill fear in an intimate partner. It may be manifested in physical, sexual, and emotional abuse, limitations on access to family members, friends, transportation, communication, food, school and work, financial control, and/or implicit or explicit threats to harm their children, their family members, their pets, belongings, and other members of the community.

Coercive control effectively traps the victim and removes their sense of individuality and freedom in the relationship.

It is the repeated and cumulative effect of this behaviour that creates coercive control. Some common law jurisdictions have already moved to criminalize it, and we know our Parliament has been reviewing similar proposals.

Our coalition submits that the police may find this more useful than the codified forms of assault now currently in the Criminal Code.

Eighth. As you've heard in the evidence in this case, and as I'm sure you know from your own life experience and intuition, there are people who want to help. There are people who want to find ways to protect victims. We need an approach that is more than just a pamphlet. The average Canadian should know what to do when they witness domestic violence. They need to know what resources they can turn to.

As Katrina Scott told the Commission at one of the roundtables, people know what to do when someone has a heart attack, but they do not know what to do when they witness intimate partner violence.

There needs to be training in hospitals, schools, and workplaces so co-workers, colleagues, and professionals know what to do.

1 The vast majority of Canadians -- and I'm sure everyone in this
2 room -- would step in and stop intimate partner violence if they saw it, but would you
3 know what to do, and would you know where to send the victim and abuser? Would
4 you call the police? And what kind of response would you expect from the police?
5 These are complex issues and the resources exist, but the
6 resources don't get the funding or distribution that they need.
7 Ninth and finally, the Commission should loudly and clearly identify
8 the paucity of funding for such a major issue. Were it not for the stigmas attached,
9 stigmas that largely blame the victim, I'm certain we would have dealt with this issue
10 decades ago.
11 Canada has tackled many difficult issues over its history, and while
12 we have not repaired everything that ails our society, when we set our minds to
13 something, we can begin to heal.
14 As you heard from one of our clients at a roundtable, she is
15 departing a role because of unsustainable funding that cannot be relied on. She no
16 longer feels she has the resources to continue her good and necessary work.
17 Intimate partner violence is an invisible yet pervasive cancer that
18 we allow to be treated for funding purposes like one-off tourism campaigns.
19 We do need the counsellors, educators, advocates, lawyers,
20 doctors, police, neighbours, and everyone to know we have a problem and we can fix
21 this problem.
22 Substantially cutting funding or treating every program as
23 conditionally funded from one year to the next sends a clear message, those in power
24 do not care. It does not affect them. They are not poor, they are not abused, they have
25 not themselves been trapped in a cycle of poverty and violence.
26 We ask the Commission to send a clear message to governments
27 across Canada that intimate partner violence is horrific, that it is everywhere, and that it
28 can be treated.

1 My grandfather was a product of his time. He died a few years
2 before I was born. He was violent, he was an alcoholic. Perhaps it was the dead
3 children he pulled out of rubble during the war. Perhaps it was the workplace injury as a
4 stevedore in St. John, New Brunswick that trapped him in poverty. There were no
5 resources for him. There were no resources for my grandmother or my mother, but they
6 got out alive.
7 That was not the obvious outcome. The likely outcome was that
8 they be drawn back into those cycles of poverty and violence, and me with it.
9 We need resources for these victims and abusers. It's cold and
10 callous to suggest perpetrators and victims alike pull themselves up by their own
11 bootstraps. That ignores the luck and chance and intergenerational trauma involved. It
12 ignores our history of violence as Canadians. It ignores the marginalized communities
13 who cannot even call the police for help.
14 When these issues are ignored or marginalized, we get spillovers
15 such as the murders of April 2020. Every time a woman is hit by her partner or a child
16 witnesses that violence at home, it affects all of us. We should not ask how does
17 intimate partner violence affect me? We must know I am part of society and this
18 violence is my responsibility to stop.
19 I paraphrased the well-known "No Man is an Island" sermon by
20 John Donne at the beginning, so I'll paraphrase it for my conclusion.
21 "Any women's death diminishes me because I am
22 involved in womankind, and therefore, send not to
23 know for whom the bell tolls. It tolls for thee." (As
24 read)
25 Thank you.
26 **COMMISSIONER MacDONALD**: Thank you so much, Mr.
27 Goodwin.
28 **COMMISSIONER STANTON**: Thanks to Participants and their

1 counsel for the submissions today, which of course, we will consider carefully, as we do
2 all the submissions that you make.
3 Tomorrow, we'll have more submissions from Participants. We are
4 going to be starting at 9 o'clock tomorrow instead of 9:30, so you'll have to get on the
5 road a bit earlier for those of you coming from out of town. Thank you for that.
6 Please remember we're still welcoming submissions from the public
7 with your ideas for change, and you can find more information about how to do that on
8 the website.
9 So thanks very much, and we'll see everyone again tomorrow.
10 Thank you.
11 **REGISTRAR DARLENE SUTHERLAND**: Thank you. The
12 proceedings are adjourned until September 22nd, 2022, at 9:00 a.m.
13 --- Upon adjourning at 1:56 p.m.
14
15 **C E R T I F I C A T I O N**
16
17 I, Sandrine Marineau-Lupien, a certified court reporter, hereby certify the foregoing
18 pages to be an accurate transcription of my notes/records to the best of my skill and
19 ability, and I so swear.
20
21 Je, Sandrine Marineau-Lupien, une sténographe officiel, certifie que les pages ci-hautes
22 sont une transcription conforme de mes notes/enregistrements au meilleur de mes
23 capacités, et je le jure.
24

25 ______________________________
26 Sandrine Marineau-Lupien
27
28