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. Benjamin Perryman	Counsel / Conseiller
Ms. Samantha Parris	Counsel / Conseillère
Ms. Nasha Nijhawan	Counsel / Conseillère
Ms. Lori Ward	Counsel / Conseillère

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Truro, Nova Scotia

--- Upon commencing on Friday, September 23rd, 2022, at 9:30 a.m.

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

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

Please join us in remembering those whose lives were taken, those who were harmed, their families, including those here in Nova Scotia, across Canada and the United States, and all others affected by the April 2020 mass casualty in Nova Scotia.

(SHORT PAUSE)

COMMISSIONER FITCH: Today will conclude public proceedings for the Mass Casualty Commission. Later today, my fellow Commissioners and I will share remarks looking at everything this inquiry has covered so far and acknowledging the many, many people who have contributed to our work.

We will also look ahead to the Commission’s next steps, including talking about the final report and the critical role that policymakers, institutions, groups, communities, and members of the public will need to play in implementing the recommendations. As we have said before, and we still believe, community safety is a shared responsibility and a shared opportunity.

This morning, we will begin by hearing more final oral submissions from organizational participants. Ben Perryman will begin, followed by Samantha Parris, Nasha Nijhawan, and Lori Ward. Before we start with submissions today, Commission counsel will be marking some exhibits.

Mr. VanWart, please, if would join us for today’s documents.

MR. JAMIE VanWART: Good morning. So over the course of the

Mass Casualty Commission public proceedings, there have been 31 foundational documents that have been presented and marked as exhibits. The purpose of these foundational documents is to share our understanding of events leading up to, during, and following the mass casualty. These foundational documents have helped the Commission what it has learned in a efficient and succinct way.

The detailed narrative set out in the foundational documents reference source material, all of which is readily accessible on the Mass Casualty Commission website.

The foundational documents were created through an extensive review of subpoenaed materials, independent investigations and inquiries made by the Mass Casualty Commission, consultation with participants, and information that has been received in hearings and provided by the public.

The foundational documents were never meant to be stagnant. As the Commission a wide variety of input over the past several months, the Commission's understanding has evolved, and so changes are needed to the narratives set out in these documents.

Today, I present 25 addenda and errata, each corresponding to a foundational document. "Addenda" is simply the plural of "addendum" and means additional materials appended to a document, while "errata" is the plural of "erratum" and simply means a list of corrections -- or sorry, a list of corrected errors appended to a document. These addenda and errata incorporate additional information we have learned through the public proceedings and input from participants and the public. They also correct errors that have come to the attention of Commission counsel since the foundation documents were first made public.

I would like to emphasize that the addenda and errata submitted today are not the Commission's finding of fact. Those will be set out in the final report which can only be written after we review submissions and the complete record of evidence collected and shared by Commission.

Madame Register, if you could please mark as exhibits each of the following addenda and errata and the associated source material. And Ill go through each one by one.

The first is COMM0064786, “Portapique, April 18/19, 2020, Addendum and Erratum”.

COMM0064507, “First Responder Actions in Portapique, Addendum and Erratum”.

COMM0064502, “Containment Points in and around Portapique, Addendum”.

COMM0064511, “Overnight in Debert, Addendum and Erratum”.

COMM0064499, “2328 Hunter Road, Addendum”.

COMM0064508, “Highway 4, Glenholme, Addendum and Erratum”.

COMM0064512, “Plains Road, Debert, Addendum”.

COMM0064510, “Onslow Belmont Fire Brigade Hall, Erratum”.

COMM0064516, “Shubenacadie, Addendum and Erratum”.

COMM0064509, “Highway 224, Addendum and Erratum”.

COMM0064503, “Enfield Big Stop, Addendum and Erratum”.

COMM0064513, “Police Paraphernalia, Addendum and Erratum”.

COMM0064514, “Confirmation of Replica RCMP Cruiser, addendum and erratum”.

COMM0064506, “Firearms, addendum and erratum”.

COMM0064504, “RCMP Emergency Response Team, addendum and erratum”.

COMM006450, “RCMP Command Post Operational Communications Centre and Command Decision, Addendum and Erratum”.

COMM0064518, “Truro Police Service, Addendum and Erratum”.

COMM0064514, “RCMP Public Communication, April 18/19, 2020, Addendum and Erratum”.

COMM0064500, “Air Support, Addendum and Erratum”.

COMM0064784, “Halifax Regional Police and Halifax District RCMP Operations, Addendum and Erratum”.

COMM0064517, “TMR-2 Radio Communications System in Nova Scotia, Addendum”.

COMM0064785, “Information-Seeking from Families and Next-of-Kin Notification, Addendum and Erratum”.

COMM0064787, “Support Services for Survivors, Families, and Communities, Addendum and Erratum”.

COMM0064519, “Perpetrator’s Violent Behaviors Towards Others, Addendum and Erratum”.

And finally, COMM064505, “Perpetrator’s Financial Misdealings, Addendum and Erratum”.

And it those, along with the source could be marked as exhibit, Madame Register.

THE REGISTRAR: So exhibited.

MR. JAMIE VanWART: Thank you.

And also today ask Madam Registrar to mark an additional 121 documents as exhibits. These documents consist of relevant materials including 33 transcripts of interviews conducted by the Mass Casualty Commission.

Madam Registrar, if those documents could also be marked as exhibits?

REGISTRAR DARLENE SUTHERLAND: So exhibited.

MR. JAMIE VanWART: And Commissioner, all of these documents marked as exhibits today have been shared in advance of today with participants. Thank you.

COMMISSIONER MacDONALD: Thank you, Mr. VanWart.

We'll now ask Mr. Ben Perryman, representing the East Coast

Prison Justice Society and the BC Civil Liberties Association. Thank you.

--- SUBMISSIONS BY MR. BENJAMIN PERRYMAN:

MR. BENJAMIN PERRYMAN: Good morning, Commissioners. My name is Benjamin Perryman, and as Commissioner MacDonald just said, I am appearing today on behalf of a coalition of the BC Civil Liberties Association and the East Coast Prison Justice Society.

For those participants and members of the public who may not know these organizations or why they are participating in this important inquiry, BCCLA is the oldest and most active civil liberties and human rights group in Canada. It focuses on the relationship between people and the state, and the ways in which the state can limit or advance rights and liberties.

The East Coast Prison Justice is a collaboration of individuals and organizations working to advance social justice through advocacy, focused on the rights and interests of criminalized imprisoned people. It raises awareness of the socioeconomic, political, and institutional in the qualities that impact marginalized people and communities in Nova Scotia and the Atlantic region.

Both organizations have extensive experience in pursuing accountability where state actors harm the public, including in the context of policing.

The coalition formed to share this expertise and state accountability with the Commission as it explores the causes, context, and circumstances giving rise to the mass casualty, and to ensure that in making recommendations about public safety in response to what was a catastrophic failure of policing in this province, the Commission does not unwittingly cause harm to vulnerable and marginalized groups in our society.

I'm going to speak to three issues or topics today. The first is challenges facing the Commission as you move into the report writing phase of this process; the second is the theme of police governance, oversight, and accountability; and the third is alternatives to policing.

On this issue of challenges facing you, there are two components. There's the challenge of impact and there's the challenge of obstruction. They're distinct but related challenges.

On the question of how best to have impact, that is, how best to make sure that the work of this Commission changes public safety in this province, several Commissioners have spoken about the importance of making recommendations that can be implemented and will have an impact. We've heard that call and we will do our best in our written submissions to provide precise and implementable recommendations.

But there is a risk of focusing too heavily on implementation at the expense of re-imagining what public safety could look like in this province and elsewhere.

The record before you reveals that the public safety status quo severely failed Nova Scotians. Tinkering with that status quo, or worse, pouring further public resources into that status quo will not prevent the types of failures that contributed to the mass casualty. It will not prevent this type of event from happening again.

So as you engage with the question and challenge of impact, we urge you to consider what re-imagining public safety could look like in this province and elsewhere.

On the challenge of obstruction, the record before you reveals what has been a hostile stance taken by the RCMP towards this Commission of Inquiry, and the public more generally, that has made your work more difficult. This requires comment, both today and in your report.

In the aftermath of April 18th and 19th, many Nova Scotians were shocked and heartbroken by the loss of life. Particularly for those not directly affected, we saw that on several occasions, those who were killed had gone to check on their neighbours and to see if they needed help. This is something that many Nova Scotians

would have done, is the type of mutual aid and care that is at the core of public safety in this province.

By contrast, the RCMP's first instinct was to take steps to avoid and evade public accountability. Within a matter of days, the RCMP were aware of a number of relevant facts, that the perpetrator was known to them, that there had been multiple complaints received by the RCMP concerning the perpetrator's violence, that these complaints were shared with different officers and not properly investigated, that one of the officers who failed to investigate had befriended the perpetrator and spent considerable time with him, that an internal police safety bulletin had been created in 2011 warning that the perpetrator wanted to "kill a cop" and had several rifles and a handgun in his home, and that a timely public safety alert and the use of the Alert Ready System would have saved lives.

The RCMP's response to this was not to come to the public and say, "We've made mistakes. We're going to fix those mistakes. We've learned from them."

Their first response was to call the entirety of this Procedure Communications Team into the office who had been working at home. This team then produced false and misleading information about what the RCMP knew and when they knew it on issues like the number of victims, whether or not all of the victims were adults.

The RCMP attempted to get other policing agencies to take a unified stance on the non-efficacy of Alert Ready. When this failed, the Strategic Communications Group developed the catchphrase that Alert Ready was not a "tool in the toolbox".

This, of course, was a half truth. Missing from this statement was that the RCMP had been asked to add this tool to their toolbox, but it expressly declined.

The RCMP attempted to get the Truro Police not to release the

public safety bulletin. Chief MacNeil said in response that he did not think that this was the ethically correct or morally correct thing to do, and as a result, this document was released to the public.

The RCMP ensured that Chief Supt. Campbell's request for an external review died on the vine and went nowhere.

Once it was clear that there was going to be a public inquiry, the RCMP tasked the spouses of H Division leadership to be on the inquiry team. Those individuals created false and misleading business cards suggesting that they're a part of the Commission staff.

The RCMP's approach to disclosure throughout this proceeding has been lethargic and troubling. Documents have been held back without notice to the Commission. Critical documents have been released at the eleventh hour. Counsel for the Attorney General of Canada has even advised senior RCMP officers to withhold material information unless they are asked.

This posture has limited your ability to get at the truth, and it has limited participants' ability to engage with the record. The public may never know if there has been complete and frank disclosure by the RCMP in these proceedings.

When senior officers have testified, they have displayed a surprising lack of knowledge about the events in question. What stands out for the coalition in particular is Commissioner Luckie, as leader of the RCMP, who came before you and described herself as a "facts gal" but could not explain why she was not in position -- possession of relevant facts.

She explained this lack of knowledge based on her 10,000-foot observational posture and a lack of briefing up.

Our coalition's view is that when organizations fail, leaders then need to get down in the trenches, figure out what went wrong, and take steps to ensure that it does not happen again. This was clearly not done.

I've belaboured these obstruction examples for two reasons. First,

they require an explicit accounting in your report. Failure to do so will incentivize this type of behaviour in future public inquiries.

Second, it must be taken into consideration when thinking through the question of implementation, the RCMP has not behaved as a neighbour or as a community member that's committed to public safety. Rather, they have repeatedly engaged in exercises of avoiding accountability, and if they continue this behaviour after your report is published, they are likely to be a serious barrier to implementation.

I will now speak to the two themes that we intend to provide detailed written submissions in our final submissions to the Commission. The first is police governance.

The record before you reveals that many of the failures of the RCMP were not a question of resources, both on the nights in question and in the lead-up to those days.

Police services in Nova Scotia appropriate substantial amounts of public resources and are often the biggest line item in municipal budgets. HRM, for example, spends approximately $130 million per year on policing. It amounts to approximately 15 per cent of the municipal budget.

Our Phase 2 submissions detailed how the many failures of the RCMP before, during and after April 18th and 19th were not a matter of resources and were instead the result of inadequate governance, oversight and accountability

I would pause here just to say that there has been some discussion of the role of research throughout Phase 2 and moving into Phase 3 of your work. Our view is that the research team has done an incredible job throughout this Commission. Canadian courts have been clear that you cannot make factual findings on complex social issues without an appropriate record. The work of Dr. Cunliffe and her team has provided that record to you, Commissioners.

What it reveals unfortunately, is that police in Nova Scotia are not subject to meaningful civilian oversight. Nova Scotia has failed to modernize its policing

standards in a timely fashion. It reduced its police auditing team from a complement of eight people to one person. It has allowed several municipal Boards to operate, if they sit at all, understaffed, and it has funded them to fail.

Municipalities provide these Boards with operating budgets that are not commensurate with the complexity of the oversight task or proportional to the size of policing in municipal and provincial budgets.

There's limited evidence that the complaint process is accessible to citizens, let alone marginalized groups, and that it has prevented the types of illegal and disproportionate policing of Africa Nova Scotian's indigenous people and others.

Commissioner MacDonald, you know this very well that it was your legal opinion on street checks that changed that practice in this province. It was not the internal complaint process; it was not existing oversight mechanisms. It took a legal opinion from yourself and Jennifer Taylor to effect change on that practice.

Canada, for its part, has been told time and time again that there are serious conduct problems within the RCMP. As Justice Bastarache has explained in his report that is before you, there's a toxic culture of misogamy in the RCMP that has been allowed to fester unchecked. And Canada has not taken steps to fix this problem.

Canada has also not resourced its Civilian Review and Complaints Commission with the capacity to do systemic reviews of policing. As Commissioner MacDonald observed, this limits the independence and ability of that entity to respond to the types of concerns raised by Justice Bastarache.

Some concrete examples that we have seen of how this manifests in specific facts that are related to this particular mass casualty, I would draw you to Constable Wiley's 2006 and 2007 Annual Assessment. This is COMM 0063642. It's a document that was again disclosed at the eleventh hour and which the RCMP and the National Police Federation attempted to exclude on untenable grounds of personal privacy.

In it, it notes that a female member of the public made a complaint

about Constable Wiley in his first year of service and that this was dealt with informally. It notes that there was another complaint that same year about Constable Wiley concerning inaction on a file and untimely investigation of complaints that he had received.

The assessor says: "Constable Wiley must remember however to never get personally involved with the clients and always ensure that his contact with them is professional and beyond reproach". It then says: I feel that he has learned from his experiences during his first year and expect these negative comments in this category will never be repeated". They were repeated. We saw that they were repeated with respect to the perpetrator in its identification of this person as a pro-police member of the public and "good guy" who did not merit scrutiny, even in the face of actual complaints. They were repeated in Constable Wiley's dismissal of Susie Butland as someone who was not the victim of a crime and did not need the protection of police. And of course this had catastrophic results.

Beyond oversight, the Coalition believes that the province of Nova Scotia needs to democratize its approach to police governance and accountability. This means governance and accountability in a proactive manner, rather than a reactive manner.

The central point here, is that there needs to be rules in place before there is misconduct to protect the public, that we cannot just deal with police misconduct through the exclusion of evidence or suing for monetary damages.

What democratic governance could look like includes involving community members, particularly those most affected by policing in the governance and oversight of police. Here we make specific reference to indigenous people, black people and people with mental disabilities.

Communities that have largely been excluded from the Commission's processes notwithstanding the facts that statistics show these communities are disproportionally targeted and harmed by police in Canada.

Democratic policing could also include developing policing standards in a transparent fashion and with the direct input of civil society organizations and others requiring police services to justify their budgetary asks and operational decisions and opening police services to data sharing external review and inquiry.

The object of this exercise of democratizing police governance is to enhance legitimacy, to protect the public and to ensure that money spent on policing is effective in terms of providing public safety for all citizens.

The second area that we'll be making recommendation on, is alternatives to policing. There was wide spread consensus amongst police, government and other participants who appeared before you that developing alternatives to policing is crucial to public safety.

Some reasons provided in support of these alternatives include detasking police so that they can focus on more discrete or emergent police functions; ensuring that people who respond to calls for help have the correct expertise or skill set; and acknowledging that police have extremely low entry requirements but receive some of the highest public salaries. So a shift to other professionals can provide higher degrees of education and expertise at substantially lower costs. In other words, we can do more with less when we ask others to contribute to public safety.

But there's a more fundamental need to develop alternatives to policing, and that is the reality that policing as a practice cannot solve many of the social problems that endanger public safety, especially for those who are most vulnerable. In other words, the blunt tool of enforcement, prosecution and jail often does nothing to keep the public safe. It may also expose some members of our public, especially on grounds of indigeneity, race, disability and poverty to state violence.

Alternative to policing casts a wider protective shield where it is more needed and more likely to be effective. You've heard that some of these options already exist, for example, in the context of police non-involved mental health teams that are being tested in some jurisdictions, but you've also heard that they are

chronically under-funded or deprived of stable core funding that prevents them from being able to play a meaningful public safety role.

It's time to sustainably and continually fund these services that are backed by evidence and implemented by people who are experts in their field and act with an ethic of care towards the communities they serve, programs that are proactive and responsive to the harms that communities are facing.

Doing so will provide better returns on investment for public safety than funnelling more and more resources to policing that are unable or unwilling to provide the protection that the public needs.

I want to end today by observing that Nova Scotian are well aware that this public inquiry only exists because of the advocacy of the families whose loved ones were taken from them and because other Nova Scotians joined them to demand accountability.

The Federal Government did not want this inquiry. The Provincial Government did not want this inquiry. And the RCMP definitely did not want a public inquiry. The entities knew that a public inquiry would uncover catastrophic policing and governance failures that contributed to this mass casualty.

We owe a debt of gratitude to the families for exposing these uncomfortable truths, and we owe them our shared commitment to making your report and the recommendations contained therein the starting point for transforming public safety in this province.

Those are my submissions. Thank you very much.

COMMISSIONER MacDONALD: Thank you, Mr. Perryman.

Ms. Samantha Parris.

--- SUBMISSIONS BY MS. SAMANTHA PARRIS:

MS. SAMANTHA PARRIS: Good morning, Commissioners. Thank you for this opportunity to make brief oral submissions.

My name is Samantha Parris and I, along with my learned

colleagues, Edward Gores and Glenn Anderson, represent the Attorney General of Nova Scotia, which I will refer to as “the AGNS” or “the province” throughout these submissions.

On behalf of the province, we acknowledge the immeasurable loss suffered by the families and friends in April 2020. The province extend its heartfelt condolences to the families and friends of those whose lives were taken, those who were harmed, and those who were, and to continue to be, affected by this horrific event. Our thoughts are will all of you.

The role of this Commission was to investigate and make findings of fact on matters related to what happened and to make recommendations to avoid such tragic events in the future. Those matters identified in part of the OIC mandate were to include the causes, context, and circumstances giving rise to the tragedy; the response of police, including both the RCMP and municipal forces; and the steps taken to inform, support, and engage victims, families, and affected citizens.

In Part B of its OIC mandate, the Commission was to examine a number of issues related to the matters just discussed, including contributing and contextual factors, access to firearms, communications, policies, and et cetera. In support of that investigation and fact-finding mission, the Commission had the power and obligation to summon witnesses to give evidence and in writing on oath or solemn affirmation.

In these submissions today, we cast a lens on that evidence heard and received to you under oath and on the volumes of information provided to you and received by you.

The Commission’s hearings are restricted in scope by relevance to the terms set out in its OIC. While the Rules of Evidence do not apply strictly here, you work is still bound by fairness. Examination of the evidence before you requires close scrutiny in order to avoid drawing improper deductions or conclusions from what you have heard and what you might deduce on your own from untested on incomplete

information developed through the investigations conducted of behalf of you, Commissioners, by your staff.

You task includes ensuring a proper balancing of reliability of the evidence that you received and what weight, if any, to give to it. This is particularly true when considering the absence of traditional witnesses and primary documents and whether any adverse findings or inferences are in issue. The strength of your recommendations we look forward to receiving from you will flow from the manner in which you make and report your findings. It is clear the task ahead of you is enormous.

During Phase 2 and continuing into Phase 3, we heard from experts, locally and from across the globe, on topics such as police culture and training, alerting the public to emergencies, gender-based violence, and beyond. We've also heard from citizens, those who contribute to community safety, those -- and advocacy groups on their perspectives and opinions on how to make our communities safer.

This inquiry has also engaged key people within the Provincial Civil Service to provide important information and context but has also afforded those same people the opportunity to reflect on lessons learned and how best to serve the public in the future. This inquiry has been an extraordinary learning for those who are dedicated to making our communities safer.

The province has been fully engaged throughout these proceedings and it will continue its work moving forward to the receipt and consideration of your final report and recommendations.

Throughout, the public has heard a lot about evidence, and we have also heard a lot of perspectives about what evidence is, what evidence means, what "best evidence" is, and what evidence may not be reliable, or what is not evidence.

It is really important to distinguish between evidence and information available to you as you move forward and make findings. For example, someone who provides oral testimony is providing evidence, but submissions of counsel are not. Likewise, contemporaneous business records produced in the course of one's

employment is likely evidence, but ideas shared during roundtable discussions is information.

As stated earlier, the province encourages you, Commissioners, to ensure that you are making findings based on the best and most reliable evidence and describe those findings, and the basis for them, in your final report.

With respect to the recommendations, the AGNS suggests that they be specific in terms of which level of government would be responsible for implementation. This is particularly important in this instance where all three levels of government -- federal, provincial, and municipal -- will be undoubtedly reviewing and responding to many of your recommendations.

I now turn to a brief review of those provincial offices and departments that have been engaging in supporting the public safety initiatives before, during, and after the mass casualty. We'll provide a much more comprehensive review in our written submissions that will follow later.

So I will not turn my attention to the Public Safety and Field Communications is an office within the Department of Service Nova and Internal Services. This office is responsible for managing the public safety communication systems in Nova Scotia which includes the TMR-2 radio system and a provincial dispatch centre commonly referred to as "Shubie Radio".

Earlier, I referred to the important distinction between evidence and information and the importance for this Commission to utilize the best available evidence when considering recommendations. This is an important concept to keep in mind when considering of the TMR-2 radio system, specifically because the TRM-2 radio system, as we've heard, is very complex.

Fortunately, the Commission has evidence from those best situated to speak to the technical capabilities of the system, including Trevor MacLeod who a professional engineer and the Director of Public Safety Radio for Bell Mobility Inc., and from Todd Brown and Matt Boyle who are both Directors with the Public Safety

Field Communications Office.

During these proceedings, we heard that the TMR-2 P-25 radio system is an interoperable public safety communication system that is supported by an independent network.

What that means is, that all first responders and others who contribute to public safety are able to communicate with each other efficiently and safely through a single radio system. Being on an independent network means that the radio system is not dependent on cell phone coverage.

We heard from RCMP witnesses describing about the difficulties they had using their radios on April 18th and 19th, 2020. However, we also heard from Trevor McLeod, Todd Brown and Matt Boyle on June 9th, 2022 that the TMR 2 radio system worked exactly how it was designed to work.

It is evident from the evidence and material before the Commission that the likely cause of the RCMP's radio difficulties encountered during the event was the officers' misunderstanding about how the radio operates, a lack of use of its capabilities, a lack of practice with the radios and not the actual system.

For example, we heard from RCMP Staff Sergeant Jeff West and others speak about how a radio signal is determined by -- or linked to cell phone coverage. It is not. It is important for the TMR 2 user community and the public to understand that these radios work on a completely different network than cell phones and as a result, radio coverage in Nova Scotia is far more robust than cell phone coverage.

This is just one example of misinformation that existed about the capabilities of the TMR 2 radio system.

We heard from many RCMP witnesses that they were not familiar with the tones or sounds that come from the radio, which also may have led to some misconceptions about how reliable the radio system was during the event.

We also heard that using these state of the art radios requires

some muscle memory in order to effectively use the full range of functions, especially in times of urgency.

We understand that the RCMP have recently implemented weekly testing of the emergency request talk buttons and encourage all users of the TMR 2 radio system to practice these, using these full range of functions as often as possible. These practices will improve first responder communications, particularly in times of emergency.

It is also important for the TMR 2 user community to understand that the staff of the Public Safety and Field Communications Office can provide communications assistance during critical incidents. This office can monitor radio traffic in real time through the Genesis Software and can offer a site on wheels which can enhance coverage in a particular area. The office can also offer assistance in the event of infrastructure failures. These are important functions and it is submitted that such assistance would be an asset to any response in a critical incident.

It is the AGNS's submission that the evidence heard supports that the TMR 2 radio system operated as it should on April 18th and 19th 2020 and that the underlying network and technology was not the source of any difficulties encountered by some users.

A participant urged the Commission to consider recommending a complete overhaul of this system, however there is no evidence to support this suggestion. The evidence we have heard in this proceeding supports recommendations that one, enhance user training, two, enhance practice, and three, enhance organizational understanding of the radio system and of the dedicated expertise through the Public Safety and Field Communications Office.

The evidence in this regard is clear. The infrastructure was not the issue.

I will now make some comments about Victim Services. Victim Services is a program within the provincial Department of Justice and its mission is to

reduce the effects of crime on the people of Nova Scotia.

This is done through a range of services. Victim Services helps to provide the victims of crime with -- and those who support victims, with information, support and assistance as a case moves through the criminal justice system.

Victim Services acted immediately in the aftermath of the April 2020 shooting while continuing its regular services across the province. By May 5th Victim Services, with the support and collaboration of the wider Nova Scotia Department of Justice, including Sheriff Services and Correctional Services, the SchoolsPlus Program, the Department of Health & Wellness, the Nova Scotia Health Authority and the Department of Community Services and a variety of community leaders, stood up in person navigational services in Portapique and in the surrounding impacted communities of Debert, Wentworth and Shubenacadie.

These navigation centres were initially open six days a week and were open to anyone in the community to attend. When citizens attended they were provided with trauma support, information and support to help them find other services they needed. These navigational centres came together quickly drawing from a group of people who had the skills and capacity to help, marshalling a variety of government resources and did so safely, even through the height of the Covid-19 pandemic.

Two of the navigational centres operating out of schools were closed in August of 2020 to accommodate the upcoming school year, while the other navigational centres were closed in January 2021 based on ques received from the community.

In-person assistance continues to be available and is provided in other ways and is also available upon request.

Victim Services has, from the beginning, provided consistency and presence in providing support and guidance to affected communities, families and individuals. We intend to explore the nature of this important work and these relationships in our written submissions.

I now turn my comments to the Department of Health & Wellness. As you are likely aware, health services provided to Nova Scotians are provided through the Nova Scotia Health Authority and the IWK and the multitude of health professionals located across the province.

You are aware too that after the mass casualty the health authority and the IWK mobilized crisis teams to the health zones most affected. The health authority and the IWK also offered specialized and relevant training to clinicians, programs and services to affected residents and supports to their employees.

The province also promoted the provincial mental health and addictions crisis line, which is available across the province, 24-7, as well as the mental health and addictions central in-take line. With these services a resident who has concerns about their mental health or the mental health of others, can access skilled crisis clinicians by dialing the crisis line, or access mental health and addictions services by self-referring to the mental health and addictions in-take line.

In addition, the province has increased resources with 211 Nova Scotia to provide a focussed point of access for available supports. Community navigators are available 24-hours a day, seven day a week to connect Nova Scotians with appropriate supports.

The province also added additional professional resources to the Family Services Association of Eastern Nova Scotia to increase access to their counselling and help line, support lines.

Other help lines which were implemented in collaboration with the Department of Community Services, have also been established. These help lines include the Men's Help Line, the Women's Help Line and the All Gender's Help Line.

I will now discuss the Public Safety and Security Division. The Public Safety and Security Division is a division within the Nova Scotia Department of Justice, and it is responsible, amongst other things, for policing strategy and public safety investigations.

It is really important to note that the Public Safety and Security Division was born out of one of the recommendations in the Royal Commission on the Donald Marshall Junior prosecution.

Through these proceedings, we have heard much information about the Public Safety and Security Division, what it does and how it operates. We have also heard about Public Safety's role in the larger context of the structure of policing in Nova Scotia.

The Nova Scotia Provincial Police Force is the RCMP through the Provincial Police Services Agreement or the PPSA between the Nova Scotia Department of Justice and Public Safety Canada.

Municipalities are responsible for their own policing and depending on the size of the population, different options are available to them to fulfill that obligation. The RCMP is one such option.

In total, there are 11 police agencies providing frontline policing to Nova Scotians. All policing agencies in the province are subject to and governed by the *Police Act*.

The RCMP also provides certain federal policing services in the province.

The Public Safety and Security Division is in the process of modernizing its existing police standards and the associated police audit program. This work is ongoing and has involved significant consultations with numerous stakeholders. This modernization project will ensure and improve uniformity of police practices across the province while enhancing interoperability.

The province encourages the Commission to acknowledge this modernization project as a positive step forward for policing in Nova Scotia and looks forward to receiving evidence-based recommendations relating to this issue.

I will now turn my attention to the Emergency Management Office. The Emergency Management Office is a division of the Nova Scotia Department of

Municipal Affairs and Housing, and is responsible for emergency planning and coordinating emergency responses.

This office works with municipal authorities to help plan for emergencies, coordinates provincial resources when there is an emergency, and helps with analysis and evaluation after an emergency.

This office also administers the emergency 9-1-1 system and the Alert Ready system.

Those who work in emergency management are truly the experts. While they do not respond to emergencies and are not first responders, their role is to understand what supports and services are needed to plan for and recover from a whole host of emergencies. The Emergency Management Office has staff on call 24/7 and will stand up in a provincial emergency coordination centre when needed.

During the mass casualty, the Emergency Management Office arranged to have Colchester County to set up a comfort centre for evacuated Portapique residents. In addition, the Emergency Management Office staff suggested to the RCMP that they issue an alert via the Alert Ready system on the morning of April 19th, 2020.

We heard evidence that EMO staff had concerns with what they were seeing on social media, along with information they were receiving from the Department of Health and Wellness, which contributed to them making the suggestion.

Even though the alerting system had never been used for an active police response anywhere in Canada, ultimately, it was made clear that the decision whether to issue an alert of any kind always rested with the police who have situational awareness. Situational awareness never rested with EMO.

While there is much debate around Alert Ready, a lesson was clearly learned. Today, the RCMP and other police agencies across the country adopted policies and as seen in recent events in Saskatchewan, now employ this system for active police matters.

Shortly after the mass casualty, working closely with the Department of Justice and EMO senior officials, the RCMP and the HRP, or the Halifax Regional Police, developed policies and training and acquired direct access to the alerting system. This allows the RCMP and HRP to issue alerts without the third-party assistance of the Emergency Management Office.

Alert Ready is now a much more utilized system, and from the province's perspective, this is a proactive, positive development in public safety.

In conclusion, the Province of Nova Scotia, in partnership with the Government of Canada, established this Commission to investigate what happened on April 18th and 19th, 2020, and to examine the broader context as to how and why it happened, and to get answers to questions many people had.

The Commission was given a broad mandate and the power to subpoena relevant information and people to provide the public, most importantly, the survivors and families of the victims, with much needed information.

Commissioners, you have received all of the information you've requested from the province, and you are fully equipped to make recommendations which work to increase public safety, to prevent another such tragedy from happening again in the future, and to mitigate the impacts of mass casualties that may occur.

The Attorney General looks forward to receiving the final report setting out findings and recommendations from this Commission.

It is anticipated that these recommendations will be of great benefit and will complement the already ongoing work of the Government of Nova Scotia to modernize its systems, policies, and approaches.

And barring those -- any questions, those are my submissions.

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

MS. SAMANTHA PARRIS: Thank you.

COMMISSIONER MacDONALD: Ms. Nasha Nijhawan?

--- SUBMISSIONS BY MS. NASHA NIJHAWAN:

MS. NASHA NIJHAWAN: I'm going to get a glass of water.

Good morning, Commissioners. My name is Nasha Nijhawan, and together with my colleagues, Kelly McMillan and Jamie Burnett, I represent the National Police Federation.

Thank you for the opportunity to provide some final remarks on this last day of our public proceedings.

I'm going to keep my remarks brief today, and will provide more detailed feedback in writing.

As you have certainly heard me say before, the National Police Federation is a union representing RCMP members below the rank of Inspector. This includes about 100 members who responded to the events of April 18th and 19th, 2020, or participated in the investigation that follows.

Today, I would like to tell you a little bit more about the NPF and about the reasons for its participation in this public inquiry, separate and distinct from the representation of our members by the Department of Justice of Canada.

I hope that this information will help you to contextualize the purpose and the nature of the recommendations that the NPF has to suggest.

To start, you and people listening may or may not know that the NPF is the first independent national association to represent RCMP members. The NPF Is a relatively new fixture in the RCMP, certified only in the summer of 2019. Representing 20,000 RCMP members, it is the largest police labour relations organization in Canada, and the second largest in North America.

The NPF's first collective agreement with the RCMP was ratified in June of 2021. I mention these dates to give you a sense of how new the NPF was to our members, and how unaccustomed to dealing with a police union/RCMP management-wise when the events of April 2020 took place.

The NPF’s members include RCMP members at the rank of constable, corporal, sergeant, and staff sergeant. Of those involved in the events of

April 18th and 19th, 2020, they include general duty members who initiated an IRIT response, rescued the Blair and McCully children, staffed containment points, and searched for an pursued the perpetrator. They include members of the Emergency Response Team, the Emergency Medical Response Team, and Police Dog Services, including those who found and killed the perpetrator. They include general duty supervisors, risk managers, critical incident commanders, and other members involved in decision making at the command post, and those members who activated during the event and spent months concluding a far-reaching investigation including general investigative, major crime and forensic identification investigators, and tactical troop members who conducted searches. They include warrant writers, public information officers, and family liaison officers, among others.

Among NPF's members are also Cst. Chad Morrison, who was shot by the perpetrator and survived, and Cst. Heidi Stevenson, who was murdered trying to stop the perpetrator after encountering him at the Shubenacadie Cloverleaf. Our members are the humans who the public sees as the RCMP but they are not "the RCMP", the institution we've been talking in this proceeding.

This inquiry is the first time that the RCMP members have had union representation in such a proceeding. Through the NPF's involvement in this Commission, we have sought to increase awareness of our members' experiences, to support individuals as they have engaged with the Commission's process, and to offer policing insight and expertise during the fact-finding and consultative parts of your process.

You have seen the NPF advocate for a trauma-informed approach to receiving our members' evidence, stand up for members actions when they were singled out and criticized, sit beside them while they provided hundreds of hours of interviews, and provide information to the Commission to help them understand what happened from our members' perspective on April 18th and 19th, 2020.

We have also sought to introduce before the Commission

evidence and information that lends insight into the post-traumatic stress injuries the NPF members suffer when exposed to a critical incident like this one. This is the job of a police union and the NPF is proud to do it. Thank you for including us in this process and for allowing us to play this role.

It is important for me during these submissions to acknowledge the important contributions that the NPF -- members of the NPF to the Commission's work over the past year and a half. More than 50 NPF members gave voluntary interviews to Commission investigators about their involvement, including many who did so from retirement or while still on sick leaves. Several others provided written statements or access to previous interviews. In addition, the Commission has heard live evidence from more than two dozen NPF members in public proceedings on difficult topics.

In addition to first-person accounts from our members during the Commission's process, the Commission has also received, and reviewed, and considered their notes and reports, their work product. The Commission has benefitted from the thousands -- findings of the thousands of hours of members' investigate work into the perpetrator's background and actions in April 2020. This information has now been entered into the public record and integrated into the Commission's foundational documents.

The NPF submits that its members have been transparent and credible in the evidence they've provided to the Commission, trying their best to assist and continue to serve the public even in the face of relentless criticism from participants and in the media, which made a difficult task more painful.

The NPF believe that their cooperation has made a material contribution to the Commission's mandate, and we are proud of the professionalism and integrity on display from our members throughout this Commission's work.

The NPF is also proud to be the unwavering voice of support for its members and to highlight their many ordinary and extraordinary successes during

the response to the mass shooting. This support for our members does not diminish the NPF's commitment to the forward-looking work of this Commission and to ensuring that the legacy of this event is positive change to improve public safety.

As you write your report, Commissioners, please don't forget to mention the bravery of our members on April 18th and 19th. Let's not forget who is responsible for killing 22 people and who is responsible for stopping him.

Before I move on to address the operational issues arising from the mass casualty, I want to address the impact that this event, the public and media response, and the work of this Commission have had on our members.

In addition to being police officers, NPF members are also community members who, along with their families, were directly affected by the mass casualty, either through their involvement in the police response or investigation or through their connection to their murdered colleague, Cst. Stevenson, who was part of their RCMP family. The deep impacts of these experiences are evident in the responses to the NPF member mental health survey, which has now been exhibited before the Commission.

Overwhelmingly, our members reported severe and persistent negative mental health impacts as a result of their involvement in these events that have only improved slightly with the passage of time. And this is just a snapshot. While those results are staggering, they do not even tell the whole story. Each of our members brought their own history of workplace traumatic exposures collected over their service careers when they answered that call for service on April 18th and 19th. This backdrop of trauma impacted how they were able to process and respond to the event and how they were able to heal.

We must also remember that many members also came to the event already burnt out from the long-term impact of chronic understaffing, excessive overtime, and over-tasking. These baseline challenges left then lacking resilience and hampered their recovery.

Since the events, our members directly affected by the mass casualty have not been able to heal in peace. Media criticism of the RCMP response and the Commission's own singular focus on our members' actions have encouraged public alienation and exacerbated feelings of isolation of our members from the communities that they serve. Our member survey showed that these experiences significantly sharpened the individual grief and loss felt by our members after this event, and also negatively impacted their wellness.

Meanwhile, the RCMP's response to the needs of its members in terms of wellness has been inconsistent and, in some areas, sorely lacking. The Commission heard evidence that the force lack a sophisticated understanding about how to best provide post-critical incident support and lacks the administrative flexibility to respond to individual needs. As evidenced from the responses to the NPF survey, our members lack confidence in the internal wellness programs offered by the RCMP, including peer-to-peer supports, and instead rely primarily on private counsellors, trusted colleagues, or family members to help them. Meaningful support for these family members, in turn, is entirely absent.

Our members need consistent attention to wellness throughout their careers and a culture that meaningfully supports healing and resilience. The NPF seeks recommendations that acknowledge and address these needs among our memberships as a critical aspect of the Commission's work.

Another aspect of the NPF's advocacy before the Commission has related to the working conditions of NPF members, including their physical safety on the job, the traditional role of a union. Throughout the NPF's submissions, the Commission may notice that we also talk of both officer safety and public safety. This is because officer safety and public safety are two sides of the same coin.

If the Commission strives to make recommendations about policing to make our communities safer, it must also consider carefully how our members can deliver those services safely. As one member candidly told the

Commission, “We can’t help anyone if we’re dead.” This is a flippant, gallows-humour version of a very serious sentiment. Our members deserve to have every available safety measure when the public are going to ask them to run towards danger to protect them.

Our members urge you to be serious in your recommendations about officer safety, including balancing this consideration against demands that our officers do more with less. You report should honour the sacrifice of their fallen colleague and the unique circumstances surrounding her death in the service of the public.

In the NPF's Phase 1 submissions, we urged the Commission to search for recommendations which address the institutional and structural limitations on our members which impact officer safety and public safety. Our members are not decision makers within the RCMP. They do not get to decide what equipment or technology they will have or not have when they need it. They do not determine the topics for their own training. They do not have a say in what policies their employer will enact that may or may not protect them when they need it most.

The RCMP, as you have heard, is a paramilitary organization with a strict rank hierarchy. Our members have little control over the environment they work in and the tools they have to do their jobs responding for calls for service, including critical incidents.

Nevertheless, it's our members who are called upon when an active shooter terrorizes our communities. They will be the beneficiaries of your recommendations.

We've heard from experts in the Commission's roundtables that the next mass casualty has never happened before, the next active shooter will not drive a replica police cruiser, or disappear down a Blueberry Field Road.

The lessons learned through this public inquiry must transcend the facts of this particular tragedy.

Building on the NPF's previous written submissions, I would like to touch on three areas where the NPF says deficiencies at an organizational and systemic level impeded members' ability to achieve their objective of locating and stopping the perpetrator on April 18th and 19th. These three areas are policing -- sorry, police resourcing and equipment, training and policies, and provincial policing standards and interoperability.

These areas will also be the focus of further detailed written submission, and I will address them only at a high level today.

First, I will address the need for police resources and equipment. There is ample support in the record before the Commission that RCMP staffing levels in Nova Scotia are not adequate to keep officers safe or to meet the public's expectations for proactive policing and responses to critical incidents and emergencies.

For example, the Commission heard that four officers were regularly responsible for policing all 3,600 square kilometres of Colchester County, and that the same is true for many other rural detachments.

The Commission heard about the consequences of a lack of dedicated, full-time ERT and EMRT members and how strained and overworked our police dog services members were during this event.

Beyond these examples, our members are stretched thin across the board. This has obvious impacts on call response times and availability of backup.

But this is a wellness issue for our officers too. The Commission has heard evidence about how understaffing impacts member wellness because it increases the risk of burnout, while making members reluctant to take leave they may seriously need because they know their colleagues will be left short staffed.

Staffing is not just an issue at the general duty level. The Commission has heard excellent suggestions from various participants about additional roles which may be necessary during a critical incident response to ensure that members are able to successfully carry out their duty to the public. We support these

suggestions, which we will address more fully in writing.

However, we wish to emphasize that for the recommendation that additional resources be made available to assist the command post during a critical incident, for those recommendations to be meaningful, the Commission must not ignore where those resources come from in the context of an already limited resource environment. We would not support recommendations which simply add specialized part-time responsibilities to existing general duty members. This has proven to be a flawed approach, as we've seen already, with respect to ERT and EMRT.

In the NPF's Phase 1 submissions and in the submissions of various other participants, the Commission has heard about the need for better radio and GPS technology, better functionality on mobile workstations, increased access to mapping technologies such as pictometry, and for dedicated adequate air support for the Atlantic region. The Commission will no doubt consider how additional equipment and technology could increase police capacity to respond to critical incidents.

Of course, the elephant in the room when we talk about the need for more human resources, equipment, or technology, is police funding. Public funds are limited. Policing competes with other public services for resourcing, and you'll hear many voices argue against increasing funding for police, while vulnerable communities face crises in housing, health, and education.

The NPF submits that this problem can be approached from both sides. On one hand, the NPF supports paths to more appropriately tasking and de-tasking police officers. For too long, our members and the police in general have been called on to fill the gaps in the absence of properly-funded mental health and social support services. The criminal justice system is not the answer to these problems. It is the line of last resort. Our members want to see more funding for much-needed critical services that address the social determinants of health and of crime, and by extension, the health of our society, including poverty and homelessness, cycles of abuse and violence, and addictions and mental health.

Those services which relieve the pressures faced by vulnerable communities in turn help to alleviate demands on police and allow our members to focus on those aspects of public safety that require and fit with their particular training and expertise.

The NPF supports recommendations from this Commission that ask our municipal, provincial, and federal governments to offer more and more stable funding for the social services needed to support the wellbeing of Nova Scotians, outside of policing. This includes support for families of victims of crime whose complex needs cannot be fully addressed by police.

On the other hand, policing requires adequate resources to enable it to respond to the most extreme circumstances, like the mass casualty. Many participants have agreed, for example, that one RCMP helicopter cannot adequately service the Atlantic region, given the inherent maintenance requirements of such an aircraft.

The NPF would be concerned about the willingness of the Commission to recommend additional air support resources without also recommending additional funding for such a major capital investment and the necessary associated staffing that it would require. It is hard to imagine finding that funding from the couch cushions.

De-tasking or streamlining existing frontline resources will not be enough. Our members' safety cannot be further compromised. We are already running short, already risking it out. Your recommendations must not make this worse for our members. We urge you to be practical and balanced in considering where additional funding may actually be necessary for officer and public safety.

Second, I would like to comment on the need for training and policies that help our members to succeed.

The Commission has had the benefit of expert evidence about how training and policies can improve policing. The NPF supports any recommendations

that improve our members' ability to respond effectively, including to critical incidents, mobile active shooters, complaints of domestic violence, and other complicated issues plaguing vulnerable communities.

Of course, training requires time off the road. In making recommendations for additional training, the Commission should be aware of the need to mitigate the impact of absences from training requirements on our frontline members. Adequate staffing is a necessary precondition to effective regular training.

Informing these recommendations, we also urge the Commission to make -- to consider how to make training or policy changes practical, accessible, and effective. Training recommendations should be based on police science, not reactions to this particular fact pattern. They should include ways to monitor the efficacy and the outcomes of that training. They must not just be written, but also taught. It is the responsibility of the RCMP to ensure that our members can understand and readily implement policy in their daily work. The Commission should address that step as well.

Finally, I'd like to discuss the need for provincial policing standards. Nova Scotia has existing policing standards, but these could be described generously as bare bones. There seems to be no dispute among stakeholders that these standards require further development to clearly establish a basic set of minimum standards for service delivery that each agency is required to maintain. We understand such work is underway.

The NPF views the implementation of detailed and comprehensive policing standards as a critical first step to ensuring interoperability between existing police agencies, including in the areas of electronic records, radio communications, computer-aided dispatch and consistent training requirements which allow integrated responses to critical incidents.

We agree that all Nova Scotians are entitled to expect the same level of policing services, no matter where they live in this province. This demands an honest conversation about what resources are required to deliver those services and

whether they can be delivered effectively under the current structure of policing in Nova Scotia.

Our members are not the decision-makers on these issues, but the outcomes deeply impact their daily working conditions and their safety. We welcome any recommendations that advance that conversation.

The NPF also share concerns expressed by others that conflict between management at the RCMP and municipal agencies may have prevented a more cooperative police response on April 18th and 19th. For example, the evidence before the Commission is that where the members and leaders of the Health Acts Emergency Response Team were anxious to help their colleagues, they were hampered by their own management team's unwillingness to offer assistance.

Where turf wars or personal squabbles at the management level prevent cooperation, our members' safety is also jeopardized. The NPF welcomes recommendations that would bring clarity to the issues currently fueling these disputes such as who bears the cost for specialized services provided by the RCMP to municipalities so that the police leadership in our province can return their focus to their public safety mandate.

Many participants have expressed concerns about the implementations of the recommendations of this Commission, and I know you want your work to have a meaningful and lasting impact on public safety. In considering this issue we've heard a lot about how past reviews have not brought any meaningful change that the public needs and our members deserve. The NPF shares these concerns.

One key difference between this Commission and past reviews or inquiries is the presence of the NPF at the table. There was no NPF to demand change for our members after Moncton. There was no NPF after the recommendations that arose from Mayerthorpe or Spiritwood. The NPF has advocated tirelessly for our members through this Commission's work but the Union's advocacy doesn't stop here.

Our objective is to improve the working conditions and the working

lives of our members and to prevent another officer's senseless death. The NPF looks forward to championing the recommendations that make our members and the public safer, including by holding the RCMP to account.

We will not shy away from recommendations that challenge the status quo at the institution because our members are the people that are impacted most directly by the policy, resources and culture of the institution.

Finally, as this is our last opportunity to speak in this room, where we have all spent so much of the last year together, on behalf of my client and of my colleagues I would like to acknowledge and express gratitude to everyone involved.

First and foremost, we would like to recognize the grief and pain of those who lost family members and loved ones to the perpetrator's violence and their dedication to ensuring that their losses motivated positive change to public safety throughout our communities and including for our members. Your advocacy has made a difference.

To the staff of the Commission, visible and invisible to us in this room, including those who keep the cameras and lights and microphones working, the Exhibits organized, the coffee flowing and the hearings running seamlessly, we thank you. We marvel every day at your quiet and unfailing competence.

Thank you also to the Commission investigators who treated our members with dignity and with compassion and to the researchers who have provided context in discussion to frame the fact-finding of the Commission.

To counsel representing families, public interest groups, the DOJs and the Commission, it has been a privilege to work with you. This has been a hard and important. We appreciate the heart you brought to this work and your commitment to advocacy on behalf of your clients and in furtherance of our shared goal of improving our community.

Finally to the Commissioners, thank you for your careful consideration of these issues and of the NPF submissions. We look forward to your

recommendations. Thank you.

COMMISSIONER MacDONALD: Thank you, Ms. Nijhawan.

We will now take a 15-minute break and after the break we will hear from Ms. Lori Ward.

REGISTRAR DARLENE SUTHERLAND: Thank you. The proceedings are now break and will resume in 15 minutes.

--- Upon recessing at 10:55 a.m.

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

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

COMMISSIONER MacDONALD: Thank you.

Ms. Lori Ward.

--- SUBMISSIONS BY MS. LORI WARD:

MS. LORI WARD: Thank you, Commissioners.

As you know, my name is Lori Ward and, together with my colleagues, Patricia MacPhee and Heidi Collicutt, I make these submissions on behalf of the Attorney General of Canada, representing the Federal Crown, including the RCMP.

Tragedy is a word we've used repeatedly during this inquiry the events that brought us here and, somehow, it isn't adequate to describe the deaths of 22 people, including a pregnant woman, whose families will ever be the same. No word is adequate.

While these events have left deeps scars in their wake for so many -- community members, first responders, including the RCMP and other police services, emergency medical personnel, and those far and wide with connections to Nova Scotia -- we want to acknowledge that most of us will never understand the pain and grief experienced by those whose family, whose friends, whose loved ones will never come home.

The RCMP was at the core of the emergency response to the mass casualty. This was an unbelievably challenging operational situation with inconceivable human impact demanding an incredibly complex investigative and organizational response, all of which was made even more challenging by a global pandemic.

We've heard much evidence about that response, and it was far from perfect. Some things when according to planning and training. Some things did not. We must study what happened and draw lessons learned. There will always be room for improvement for all policing agencies. The RCMP has expressed its commitment to making those improvements.

I'm going to be talking about hindsight as well as perception. I will give you some examples of lessons learned and some examples of what went according to plan, as well as some situations where it seems there is no satisfactory course of action. I will have some brief comments on the future, and finish with some observations about the RCMP's role in this tragedy and this inquiry. We will be speaking to recommendations in our written submissions.

I want to begin with hindsight. Hindsight is a useful tool when looking back to try to evaluate a situation with a view to learning lessons and making positive change. Hindsight can also impede a fair and objective evaluation of decisions made in real time. It is the latter we need to be weary of.

When we talk about these events being unprecedented, after more than two years, it becomes trite. We cease to ponder what exactly "unprecedented" means. These events happened. They have entered our collective history. Although the grief may not dull with time, our disbelief fades. The longer we live with these events, the harder it is to harken back to a time when we would not have imagined them. Rather than unprecedented, they have indeed become a precedent, not in the sense that we accept them as normal, but in sense that we have lived with them and now we must learn from them.

And with any event viewed in hindsight, particularly an event that

spanned 13 hours with so many people and places involved, it can be difficult to separate what was known at the time from what has become common knowledge after the fact. It is very easy to unconsciously make judgments based on what we know now. Perhaps S/Sgt. Halladay said it best when he appeared before the Commission:

> "I have so much information now that I didn't have then. It's difficult to separate what I know now from what I knew then." (As read).

There's been much criticism levelled at our RCMP members for seemingly dismissing the accounts of a marker police car from initial witnesses. This is not supported by the evidence. To the contrary, the RCMP took the information at face value and took it seriously. There's absolutely no dispute as to what was said. We have the transcripts, "A police car in the driveway, decked and labelled, a cop symbol on it."

The evidence shows that the possibility that the perpetrator had an actual marked police car was not dismissed at all. The initial RCMP response, based on these descriptions, was to account for the whereabouts of its marked cars. Its employees considered that those witnesses were describing a car like their own. As we know, once they accounted for the whereabouts of all the authentic cars, other information was coming in. Either eyewitnesses described a white car or a car that looked like a police car.

The IARD contact team noted a Ford Taurus at the perpetrator's property with reflective tape all around.

Information came in that the perpetrator owned multiple decommissioned white Ford Taurus's. A database query found that only two months earlier he had been stopped for speeding in a white Ford Taurus with some reflective striping still on it.

The RCMP reasonably turned their minds to other possible scenarios. This has been termed a failure of imagination, but that assessment is

applying a lens of hindsight.

The reality is, that except for those who had seen or knew of the perpetrator's replica police car before these events, it was beyond reasonable comprehension at the time that someone had built such a car himself. Plus, once real police cars were accounted for, it was logical and reasonable for the RCMP personnel to begin to think about other scenarios for what a police car could mean.

To assert that they should have continued to search for a car identical to their own as opposed to turning their minds to alternatives, like decommissioned cars, is to view the events through the lens of someone who has now been familiar with the existence of the replica car for more than two years and it's not reasonable.

We need to put ourselves back in a time when we had never seen that picture, and that's the problem, we can't unsee it. But if we're being honest, most of us view that photo with initial disbelief and incomprehension. Witness after seasoned police witness said the same.

This was not a failure of imagination or a failure to keep an open mind. The RCMP's reasoning in trying to figure out what vehicle they were looking for was logical and based on a breadth of knowledge and experience.

With respect to alert ready, the evidence showed that this was not a tool that was in the immediate contemplation, let alone direct operational capability of the RCMP in April 2020 for a policing application.

This is plain and obvious based on the evidence of numerous RCMP witnesses who were aware of its use for weather-related events and natural disasters or of their knowledge of amber alerts.

At the time of the mass casualty in Nova Scotia, the idea that the alert ready system could be used for a policing situation was in its infancy. In fact, it had never been used for such an event anywhere in Canada, including Nova Scotia.

There were assertions that the RCMP must have known about alert

ready because it was very high profile and was discussed at regular 9-1-1 meetings. In reality, while the minutes of those meetings reflect general discussions about the public alerting system, there's no indication there was ever any discussion about its use in policing situations. In fact, aside from tests, the public alerting system was only used for the first time in Nova Scotia on April 10th, 2020 by the Provincial Emergency Management Office to warn the public about the Covid-19 pandemic and the state of emergency in the province, which is an interesting use in itself.

One wonders how much time, planning and crafting went into that Covid alert in advance. This was a month into the pandemic and Nova Scotia had daily press briefings and the message alerted people to stay home, something they already knew. This is not an example of alert ready being used for a rapidly evolving situation, nor the use of alert ready for a policing situation,

Provincial witnesses acknowledge that alert ready was not developed with policing applications in mind except for amber alerts. We know that the Provincial Emergency Management Office gave a PowerPoint presentation to policing agencies in 2016 that referenced the possibility of using the system for policing applications and of law enforcement entities gaining direct access.

The evidence suggests that there were similar overtures made to policing agencies in the years that followed but no policing agency was interested in gaining access to the system.

There was evidence that two members, RCMP members, raised the issue of some kind of message that could be broadcast to warn the public during the events of April 2020. One was Heidi Stevenson and one was Stuart Beselt. There was no evidence that either was aware of or had alert ready in mind, in fact Stuart Beselt told Commission counsel during his interview, that he really didn't know what he had in mind.

No one, not the RCMP, nor the chiefs of other police services who appeared before the Commission, had ever used alert ready in a policing situation and

no one had any policy or standing operating procedures in place in April 2020.

Nonetheless, when the Emergency Management Office called at 11:15 on Sunday morning to offer an alert, the RCMP ultimately said yes. However, the alert was overtaken by events.

Since that time, we now know that the RCMP has studied the issue, put polices in place and obtained direct access to the system. Alert ready has now been deployed in policing operations in Nova Scotia and other provinces. The RCMP should not be faulted in hindsight for not having in place in 2020 what no one had in place. However, the progress since then indicates a willingness to adapt and improve.

With respect to the information that law enforcement agencies may or may not have been in possession of a decade or so before the mass casualty, there seemed to be unrealistic expectations of what police can do when information they receive does not provide sufficient, reasonable and probable grounds to obtain a search warrant or for further investigation,

There also seems to be a tendency to view disparate information gleaned over time in a cumulative way that in hindsight becomes capable of obvious conclusions and the perception of opportunities squandered.

What policing agencies knew then was in fact very little. The Halifax Regional Police investigated the uttering threats complaint, did not have enough information to pursue it and closed the file. To suggest the RCMP could have done a lot more when contacted by the HRP about that complaint, is not reasonable based on the facts.

Similarly, when the CISNS bulletin was issued, there was not enough for the HRP to take more interventionist action and it would seem the Truro Police Service and the RCMP were similarly situated. There was simply not enough information to enable more significant law enforcement action.

The Brenda Forbes' complaint falls into a separate category. Ms. Forbes' account of what she reported does not coincide with the manner in which that

call was contemporaneously coded by the OCC, nor with the notes or the recommendation of the responding member.

While these notes were not extensive, they do support his recollection that it was not the type of call that would have merited extensive notes. He further gave evidence that had this been a domestic complaint, it would have required more investigative action, including interviews with the perpetrator and his common-law partner.

Although Ms. Forbes asserts that she made a complaint of intimate partner violence, there is contemporaneous subjective evidence that the complaint was a disturbance complaint. Sometimes people's memories of an incident become clouded over time by information learned after the fact about the incident itself or the people involved.

In addition to a hindsight lens, sometimes our perception of things is clouded by the power of suggestion. Perceived chaos in the commend structure is a narrative fueled by a few witnesses on the ground who told the Commission that at some points during the events they did not know who was in command. In fact, those in charge were experienced and knowledgeable and knew how the chain of command functioned and who was tasked with various things. The fact that every responding general duty member didn't know the whole picture, is hardly surprising given the magnitude of the event and the response.

On the record, various senior members advised who was taking command or answered that question when asked. That doesn't mean communication can't be improved. But, again, as Staff Sergeant Halliday said in his Commission interview, "This theme that comes up about this chaotic, out of control situation where nobody knew what they doing and, you know, nobody was in charge and, you know, from my point of view I can tell you that throughout that entire event I felt that it was a controlled, systematic step-by-step collaborate approach by individuals working as a team to get the job done."

The fact that the flow of information likened to drinking from a firehose may have been overwhelming to some extent, does not mean that those in charge were any less clear as to who was in charge.

Turning to lessons learned, we now know there were many things in the emergency response to the mass casualty that did not work as they should have. Some of them relate to technology or equipment. For example, it seems that the RCMP had made the Pictometry Program available as a tool to assist members in navigating the geography pictometry program available as a tool to assist members in navigating the geography of the province.

This could be especially useful in rural areas such as Colchester County, where, as we've heard, there is simply too much territory for members to become intimately familiar with.

On April 18th, 2020, however, there was difficulty accessing the program for technical reasons. Login requirements prevented personnel from accessing the program, particularly when attempting to log in from someone else's unfamiliar workstation.

Whether pictometry would have provided better mapping or resolution of the Blueberry Field Road than Google Maps, which other members were accessing, remains in question; however, it is self-evident that a tool such as pictometry is only useful if it can be accessed when needed. If pictometry is to be the standard mapping software, access must be streamlined to enable rapid login and operation.

We heard from witnesses about the GPS option on portable radios as a solution to tracking members when they are out of their police vehicles. During a roundtable session on the TMR 2 radio system, we heard reasons why the GPS feature of portable radios was not a viable solution to increase situational awareness in a large police response.

Many other witnesses spoke of the need for a common operating picture such as the ATAK app to track the location of members by virtue of their phones

when they were not in their cars.

This would have been an invaluable tool and possibly enabled multiple IARD contact teams to be deployed. It had been available as a pilot program, but certificates had expired.

The RCMP has now made ATAK available to all ERT and police dog service members, and it will be rolled out to all general duty members by December 2023.

It became apparent that communications among RCMP members with the chain of command and with the public were challenging. With respect to radio communications among members, the Commission heard from several witnesses about the TMR 2 radio system, how it works and its inherent limitations.

A lot of evidence focused on the capabilities of the system when it was being accessed by so many parties during such an expansive event. Simply put, there is finite air time, and only one person can broadcast in a talk group at one time.

When there was urgent information to be transmitted, dispatchers would start the radio transmission with, "Break for dispatch," or "Break, break, break," signalling vital information to come. These words were also used by some members to transmit critical information about their observations.

Using the words, "Break, break, break," ensure that others would not attempt to transmit so the talk group would be available and it got everyone's attention. It is important to do this, especially when there is so much activity on the talk groups.

There were a few instances when this technique could have been used to ensure the information was received. Some critical messages were neither acknowledged nor rebroadcast as they should have been.

At one point, a member attempted several times to break into the radio channel, a common occurrence, with so much traffic, and when he did, his critical broadcast was not acknowledged.

As well, there were instances when critical information did not reach those in command in a timely way, such as the fact that there was a conscious shooting survivor, an eyewitness, at the hospital.

With respect to communications with the public, the strategy of using Twitter and Facebook has been much criticized. Such use of social media was recommended following the 2014 Moncton shootings, in which three RCMP members were murdered and two others sustained non-fatal gunshot wounds.

The evidence shows that it is an effective tool, particularly since the RCMP Twitter feed is monitored by the media and messages are re-Tweeted and broadcast to a wider audience.

Having said that, there were issues with the timeliness and content of the Tweets. Although the first 9-1-1 calls made it clear that people had been shot, the first message referenced a firearms complaint and did not convey the gravity of the situation.

Confusion as to who needed to approve messages factored into the delay in putting out the photo of the replica car, in particular. RCMP witnesses spoke of the need for better communications policy and training.

Sometimes, challenges relate to equipment. Air support was clearly an issue. As we know, there is one RCMP helicopter located in Moncton that provided air support for three provinces.

We also heard that the helicopter was down for routine maintenance, and even under optimal conditions, restrictions on flying hours and the availability of pilots could severely limit the operational capabilities of the Air Services Branch.

We learned that the process to request assistance to law enforcement from the Canadian Armed Forces is cumbersome. It must be requested by provincial authorities and approved by the Minister of Defence.

The Nova Scotia Department of Natural Resources, which

ultimately provided a helicopter, could only do so come daylight, and did not have forward-looking infrared technology to detect heat signatures.

Better contingency plans are needed to ensure that air support is available when necessary. We have already learned that such plans were in place during Saskatchewan's recent tragedy.

There were undoubtedly problems and failings in the response to the aftermath of the events. It is true that these events were far reaching and stretched every resource available to the RCMP, but it is obvious, the victims on Cobequid Court should have been discovered before Sunday evening.

The anguish felt by the families of those victims at the thought of that lapse of time is unimaginable, and we acknowledge that suffering.

Similarly, scene security at the residence of the perpetrator's last victim was mishandled. We aren't sure why the scene was released, unbeknownst to the victim's family, but we know that should not have happened.

These are just some examples of things the RCMP wishes it could go back in time and change. Similarly to training, equipment, and resources, some are simply human error. All of them are regrettable. We need to draw lessons from what happened here and make sure that these things do not happen again.

Excuse me for a second.

We also know that there were aspects of the RCMP response to these events that did go according to planning and training. The immediate action rapid deployment or IARD response is one. We learned that the IARD response was designed in response to the Columbine School shooting and is based on the premise that the primary goal in an active shooter situation must be to neutralize the threat.

As we know, the first three members to respond raced to the scene, formed a three-person IARD team, and followed their training directly toward the danger.

There were fires, there were explosions, and the sound of gunfire.

They continued seeking out the threat. Others were on route. Senior members were coming on duty to assist. The Critical Incident Package was being rolled out. This was in accordance with policy and training. The incident was rapidly evolving, as was the response.

The IARD contact team had donned hard body armour and was armed with carbines, two pieces of kit introduced as a result of earlier incidents, including the Moncton shootings and the MacNeil report which followed, as well as the Mayerthorpe incident.

The RCMP clearly does heed recommendations with tangible, positive impacts. Cst. Morrison was saved by his hard body armour, and in fact, H Division exceeds the 80 percent benchmark for carbine-trained members in the RCMP at 82.5 percent.

MacNeil recommendation 5.6 stated that during high-risk, high-stress incidents, a supervisor must clearly provide direction regarding equipment use. The transcripts show that during these events, supervisors advised members to don hard body armour and ready carbines on at least nine occasions.

As well, the MacNeil report recommended that operational communication centres should have an experienced, non-commissioned officer available to coordinate operations in critical incidents and to offer direct operational advice to call takers and dispatchers.

H Division was ahead of its time with the Risk Manager Program being implemented in 2006.

While there were undoubtedly shortcomings in the overall response to the mass casualty, many of which we acknowledged in the evidence of RCMP witnesses, there was much that went according to training and planning. Further, there has been a narrative that the RCMP can't change, that it resists change, and many have pointed to past reports and their recommendations as evidence. However, the evidence doesn't support the narrative.

When the Commission asked the RCMP to provide written evidence of what initiatives had been taken since the mass casualty, the RCMP provided a 27-page document outlining responses that had already been implemented or that were in progress. You have also heard that lessons learned from the mass casualty have already factored into the response in the most recent tragedy in Saskatchewan. Public alerting was used extensively there. In addition, contingency plans for air support were in place. When the first aircraft went up, the RCMP was already planning for the next.

In the aftermath of these events, it has become apparent that sometimes it is difficult for the police to strike the right balance in navigating the way forward. If they don't give out sufficient information quickly enough because they want to make sure it's accurate, this can be a source of criticism. If they give out too much information, particularly if information turns out to be inaccurate, they may be criticized for not having their facts straight before going public.

There's been a lot of talk about the internal and external reviews of the mass casualty and much criticism for the lack of an immediate independent review of the critical incident response. Some might not agree with the rationale for waiting until some of the other reviews were completed, but it was not unreasonable or in bad faith, based on an examination of many factors including the layers of other reviews that were already going to take place. The included the Employment and Social Development Canada and Hazardous Occurrence Investigation Team reviews under the Canada Labour Code. There was also an RCMP National Office of Investigative Standards and Practices review contemplated in the months following the mass casualty. Emergency Response Team and Emergency Medical Response Team After-Action reviews were done. In addition, almost immediately, there was talk of what would become this inquiry. And there was Covid as well as the trauma large numbers of impacted employees were still experiencing months after the tragedy.

The decision not to engage in an immediate independent review

of the critical incident response is not indicative or representative of a desire of the RCMP to shield itself from review, and it certainly is not indicative of a desire on the part of the RCMP not to examine the response in its totality and to implement change as soon as possible. In fact, some of that work was already underway.

In the immediate wake of the event, H-Division formed the Issues Management Team, or IMT. It seems that somewhat, based on the name, people have wanted to portray this initiative as "fixers from Ottawa" or "spin doctors" focused on managing messaging to the media. It was put to various witnesses that the team was only engaged in three hot-button issues perceived to be "problem" issues for the RCMP -- Alert Ready, the CIS NS bulletin, and the Brenda Forbes complain.

In reality, the IMT looked at and briefed Nation Headquarters on several other policy issues that arose. During Supt. Dimopoulos' interview, Commission counsel cited an email of May 4th, 2020, that contained the IMT's mandate with no fewer than 10 issues. However, Commission counsel only asked about few, saying:

> "So I don't propose to go through them all, but I just want to confirm a few." (As read).

Interestingly, Commission counsel focused on issues like Alert Ready citing "the intense media scrutiny or criticism surrounding these issues". There was no interest in canvassing the other issues such as uniform or vehicle disposal, the perpetrator's Nexus card, or the firearms investigation involving CBSA, the FBI, and the ATF. All of those issues were on the list in the May 4th email.

With respect to the IMT's role, Supt. Dimopoulos said:

> "There were a whole host of issues that required follow up and administrative review with regard to policy, whether new policy would be developed, research, all those -- all of those sort of issues as they became evidence had to be dealt with outside of H-Division simply because, a, there was a capacity

issue, number one, and, number two, the policyholders are centralized. These are issues that have national implications across the organization have to be driven from outside the province." (As read).

So, ironically, it seems that in an effort to be proactive in identifying issues that they could begin to examine with a view to necessary policy changes or other remedial action, the IMT has become a source of criticism.

Sometimes, answers led to more questions. Participants wondered why the first responders exited their cars and went into Portapique on foot. The answer was that driving a police car was like "driving a billboard" and the RCMP knew from its experience during the Moncton shootings that police officers in cars are like sitting ducks, at a significant disadvantage in terms of visibility. The members were better able to hear and see threat cues from outside their cars than from inside their cars. Still, given that those first responders ended up covering some 10 kilometres in the course of the night, this may have raised a perception that officer safety was emphasized over the safety of the public. There should be no doubt that public safety is paramount and police officers understand they must put the safety of civilians above their own. However, failing the risk of imminent hard, officer safety much go hand in hand with public safety since a fallen police officer is no help to anyone.

Turning to the future, any consideration of meaningful recommendations must take into account the context of policing in Nova Scotia. The Commission has heard extensively about the realities or rural policing in this province. The RCMP polices a huge geographical area of Nova Scotia. One of the difficult truths is that in rural areas, the police might not be close by; response times are longer; specialized services might be even farther away than the local detachment.

For instance, the Emergency Response Team is in Dartmouth. Without the resources to transport it by air, ERT can take hours to arrive at a critical

incident. This same reality applies to Emergency Health Services who respond to life-threatening calls for service in rural areas.

In addition, the RCMP must function within the constraints of tight municipal and provincial budgets. The RCMP is often operating at a deficit due to unfunded requests for assistance with specialized services to municipalities. This is an unfortunate reality and an impediment to the implementation of recommendations.

We heard evidence from Deputy Commissioner Brennan to the effect that the RCMP must often rob Peter to pay Paul when it comes to implementing recommendations from inquiries unless there is an accompanying investment. This means that some initiatives must give way to other despite the fact that every initiative is worth considering.

Commissioners, you have reminded us repeatedly that this inquiry is not about laying blame. Rather, it is a fact-finding endeavour intended to result in the formulation of meaningful recommendations intended to improve systems, policies, resources, or culture.

You have heard from many of the members who responded operationally to the mass casualty. You have heard from many of the most senior members of the organization, and you've heard them publicly commit to making the implementation of the recommendations emanating from this inquiry their priority. The RCMP has committed both to implementing recommendations from prior reviews and inquiries, as well as this inquiry, and to implementing changes to the organization to improve transparency, accountability, and diversity.

Finally, a few comments on the inquiry process and the RCMP's role in it. Participants, and particularly the families and friends of those who lost their lives, have rightly demanded answers in order to try to make sense of the senseless and ensure those lives were not lost in vein. Answers to some of their questions were simple, some were more complicated and some we will never know, but not for lack of trying.

We know that some participants were not always content with the inquiry process as it unfolded, but in the end approximately 90 RCMP employees gave voluntary interviews. More than 76,500 documents have been disclosed and 34 RCMP witnesses appeared to testify, from the first general duty members on the scene in Portapique, to the Criminal Operations Officer, the Commanding Officer, the Deputy Commissioner and the Commissioner.

Ultimately only two witnesses who appeared were not directly cross-examined by participants' counsel due to accommodations being granted.

We would be remiss if we did not acknowledge that RCMP personnel have also endured an ordeal of immense proportions. They may not have lost family members and nothing compares to that.

Despite their training and experience, underneath it all they are human. They are our neighbours and fellow citizens who have dedicated their careers and in some cases their lives to public safety. They too suffered harm that day, including the loss of a friend and colleague. Many were in harm's way and rushed toward the danger.

The Commission has repeatedly reminded us this inquiry is not about finding fault. This is hard. In the face of such tragedy the urge to lay blame is strong. And the person who bears ultimate responsibility is not here. His name has, for the most part, not been spoken in these proceedings.

As a result, in some sense he has become an abstraction. He is taken out of the narrative and the focus becomes what others did or didn't do to stop him.

Those who are left behind and who could not prevent the violence, are the focus of anger. The perpetrator's actions went far beyond what policing agencies have encountered before. This was a well resourced, intelligent and devious actor. The scale of his crimes had never been encountered in this country. In a quiet and peaceful rural area, under the cover of night, he proceeded to seriously assault his

partner, murder members of his own community and set fire to their homes, destroying almost everything in his wake.

After a period of inactivity, he continued the next day in a different community, seemingly targeting some he knew and others who merely crossed his path.

Many would say that but for this or that thing, that the RCMP did or didn't do, their loved one would still be alive and that is understandable. But there are two big "but for" in this scenario that we haven't really talked much about.

The first is that, "but for" that man no one would have died in those days. The other big "but for" that has not really been acknowledged, is that but for the efforts of police and other first responders, call takers, medical personnel and their support staff, no doubt more people would have died in those two days.

Yes, the response had its flaws, but it ultimately resulted in the perpetrator's apprehension. We recognize this is no comfort to those who lost someone, but the perpetrator would clearly have been capable of continuing his rampage with more lives taken senselessly.

The RCMP is the biggest police service in Canada. It has many roles and functions across the country and abroad. And while it has many responsibilities, please remember that it is also made up of committed members working in our communities and detachments such as Bible Hill, Enfield and Millbrook

Much like it's municipal partners, it has a presence and a desire to protect public safety in our communities and to respond to the needs of those communities.

The RCMP is no different in that respect. And those of its employees who responded during the mass casualty and in the aftermath, all of them were there to employ their training to the best of their ability. These horrible crimes happen in RCMP jurisdiction but the difficulties and challenges were not as a result of them occurring on the RCMP's watch. It's important to look back at critical incidents

and try to learn from them. There will always be lessons learned. But that doesn't mean those involved in the response could have prevented those events or necessarily stopped them earlier.

Police spend a significant proportion of their time planning and training but they are of necessity reactive. They're always at a disadvantage relative to a perpetrator because only he can predict what he will do. No response to a critical incident of this magnitude could be perfect, but when this crisis hit, the RCMP showed up, did their best and acted with courage, determination and dedication to apprehend the perpetrator and restore safety, because that's what they swore an oath to do.

Thank you, Commissioners, those are my comments.

COMMISSIONER MacDONALD: Thank you, Ms. Ward. We will rearrange the podium and the Commissioners will offer their final remarks.

Good afternoon every one. Bourjour à tous. We join you from Mi'kma'k, the ancestral and unceded territory of the Mi'kmaq.

Today we reach the end of public proceedings for the Mass Casualty Commission. We have achieved this thanks to the hard work of many, many people over many months.

Aujourd'hui, nous arrivons à la fin des débats publics de la Commission des pertes massives. Nous allons revenir sur le chemin parcouru, sur la façon dont nous en sommes arrivés là et sur tout ce que nous avons appris en cours de route.

Given this milestone moment, we will take a look back at how far we have come together, what we learned along the way, and what comes next. We will look ahead to the Commission's final report and the very important role we all need to play in order to put the coming recommendations to work.

From our very first day as Commissioners our work has been inspired by the memories of the lives taken and the impact of all those affected by the April 2020 mass casualty in Noa Scotia. Let's take a moment.

(SHORT PAUSE)

COMMISSIONER MacDONALD: Starting with those whose lives were taken. We pause to remember them every morning, and we carry their names with us every day.

We also think of those who were injured, and the family members and friends who lost their lives -- sorry, who lost their loved ones, here in Nova Scotia, in Canada, and in the United States.

We know that the impact of the events affected many, the witnesses, first responders, and service providers who were at the scenes, and all those who stepped up afterwards to help respond and support those most affected; the communities who lost friends, neighbours, and their sense of shared safety; and the broader public who joined with those survivors, families, witnesses, responders, and communities in shared grief and mourning.

The extent of the harm has been deep and far reaching. So much loss, so much harm, caused by one person's actions, rippling like waves.

Since the beginning of this public inquiry, our purpose has been clear; to find out what happened; to explore how and why it happened, looking into the underlying issues and root causes; then, building on everything we learned, to bring forward recommendations that can help make our communities safer.

We took on this responsibility to ensure that all those whose lives have been taken and all that harm suffered will not have been in vain.

Those whose lives that were taken were individuals, just like you and me. They contributed and they made a difference in the places they lived. We cannot -- we cannot allow this mass casualty to be the last word on their legacies.

Instead, we all must all continue to work to honour the family and community bonds that mattered so much to them, as they do to us. We must together take action to build safer communities.

There are communities just like those involved in the mass casualty right across Canada. The recent events in Saskatchewan are a painful reminder of this.

And there are lessons we can all learn and actions we can all take to strengthen community safety.

And that is why a joint national and provincial inquiry, as a joint national and provincial inquiry, our scope has been national, and we have also looked to lessons learned from beyond our borders, to ensure we can be learning from others to make improvements here in Canada.

If this seems like a broad approach, well, it needed to be. The mass casualty was the largest mass shooting in modern Canadian history. It involved 17 crime scenes. There were multiple lives taken, two others shot, and many more people harmed or affected. Hundreds of witnesses and responders were involved. And as we have learned, many thousands of pieces of evidence and related information were generated.

From the outset we faced an immense task, a very broad mandate, and an equally ambitious timeline, requiring us to complete our work in just over two years. The mandate was set out for us in orders in council from both the federal and provincial governments, providing the directions and boundaries for our work, including the requirement to explore the broader causes, context, and circumstances behind the mass casualty.

And like the rest of the world over the past few years, we also had to contend with the uncertainty and challenges of a global pandemic.

Once our work began, we also faced consistent challenges around the pace, unpredictability, and volume of document disclosure.

Despite these challenging circumstances, together with Participants and the public, we have stepped up to the work with the care and dedication it deserves.

It was important to us to build this Commission team on independence, respect, and transparency.

In early 2021, we moved quickly to bring together an expert team

from scratch, with a wide-ranging area of specialties, so we could ramp up our independent investigation.

We designed a process that would be flexible and efficient, taking full advantage of all the powers of a public inquiry to investigate, to subpoena witnesses, and to subpoena documents, but also to explore the broader root causes through wide-ranging work grounded in research and policy.

We designed an approach that would allow the different phases of our work to overlap while also building on each other. Simply put, this meant starting with a thorough investigation into what happened, then building from there to explore the underlying issues and root causes. Then, based on everything we have learned, we are now able to consider potential recommendations as well as how to make sure they are implementable.

Early in our work we made a call for Participants, bringing in those most affected individuals, families, governments, first responders, and organizations, including advocacy groups. These were the people and groups who were by our orders in council automatically granted or applied for the opportunity for appropriate participation, and who continue to have a substantial and direct interest in the subject matter of this inquiry.

As you know, Participants and their counsel have played an integral role in our work, providing feedback on our Rules of Practice and Procedure, helping to review the Foundational Documents, highlight material gaps and issues, identifying and questioning witnesses, contributing to roundtables and other discussions, and providing regular written and oral submissions like the ones we have been hearing this week.

We know that not all Participants have always agreed with our decisions or our approach at every step as we worked to fulfil our mandate, but despite that, they, you, have remained committed to our work and our shared goal of making sure changes happen, so that our communities will be safer. We appreciate that.

We recognize that the Participants and the wider public wanted to

know what happened. We have done everything we could to ensure that the Commission's investigation and proceedings were comprehensive and thorough.

Over the course of our work, the Commission has interviewed more than 230 people, including more than 80 RCMP officers.

Through subpoenas, we gathered tens of thousands of documents, videos, and audio files from the RCMP and others.

Our investigative work included various visits to the sites involved in the mass casualty as well.

We developed 31 Foundational Documents in order to organize, analyze, and distribute all this information efficiently. We shared them publicly with over 3,800 supporting source documents and additional exhibits, providing extensive information about what happened on, and leading up to, April 18th and 19th, 2020.

This approach meant we could be efficient and thoughtful when calling witnesses during the public proceedings, focusing on those witnesses required to address material issues and factual gaps. Before presenting the Foundational Documents, we held working meetings with participant counsel over many weeks to get their feedback and input, which was incorporated into the documents. Then, we shared our understanding of the evidence by presenting each Foundational Document during public proceedings, which further prompted investigative leads and identified errors and gaps as we went along.

Through the Foundational Documents and supporting materials, we shared our understanding of what happened at the 17 crime scenes involved in the mass casualty, for example, What happened in Portapique, April 18-19, 2020, from the perspective of the residents; The First Responder Actions in Portapique; Containment Points in and Around Portapique; What Happened Overnight in Debert; at 2328 Hunter Road; at Highway 4, Wentworth; at Highway 4, Glenholme; on Plains Road, Debert; at the Onslow Belmont Fire Brigade Hall; in Shubenacadie On Highway 224; and at the

Enfield Big Stop.

We also shared Foundational Documents about the systems and processes that had a bearing on what happened, These included: Police Paraphernalia; Confirmation of the Replica RCMP Cruiser; Firearms; Alert Ready in Nova Scotia; The RCMP Emergency Response Team; RCMP Command Post, Operational Communications Centre, and Command Decisions; the Truro Police Service; RCMP Public Communications; Air Support; Halifax Regional Police and Halifax District RCMP Operations; 9-1-1 Call-Taking and Dispatch 10; and the TMR2 Radio Communications System in Nova Scotia.

We shared additional Foundational Documents about What happened involving Information Seeking from Families and Next of Kin Notifications; Support Services for Survivors, Families, and Communities; and Public Communications from the RCMP and Governments after the Mass Casualty.

Finally, we shared Foundational Documents that organized what we had learned about the perpetrator and his background, including Violence in the Perpetrator’s Family of Origin; The Perpetrator’s Violent Behaviour Towards Others; The Perpetrator’s Violence Towards His Common-Law Spouse; and The Perpetrator's Financial Misdealings

Through a regular submission process, we invited the participants to share with us any material gaps or issues arising from the Foundational Documents that would require more exploration through witness testimony. We also called 60 witnesses during the public proceedings and hearing from them as individuals and sometimes as panels when that was the more efficient and cohesive approach.

For each witness, independent Commission counsel would ask questions in the public interest and questions that had been developed in consultation with the participants. Commission counsel would then caucus with participant counsel, meeting to determine whether participants had additional questions and in which order these would be asked to minimize duplication and maximize effectiveness. With very

few exceptions, participant counsel could question the witnesses directly.

We heard from a broad spectrum of witnesses, including experts, community members, responders, and more than 30 RCMP members, including senior officers who were in charge both here in Nova Scotia and at the national level at the time of the mass casualty. The witnesses helped us build our understanding of what happened, and how and why it happened. Some shared suggestions for recommendations as well and we were grateful to receive them.

Through the course of proceedings, we also shared 45 supplementary reports which include the results of further investigation into specific questions or events including information about the perpetrator's use of radios and scanners, information about handcuffs used in the mass casualty, and an analysis of Emergency Health Services GPS data, as examples.

All of the Foundational Documents, all of the source materials, all of the supplementary reports, all of the witness interview transcripts are available on the Commission's website. They will assist us as we prepare our final report and findings and they -- we hope they will continue to assist the participants, the public, and anyone who wants to know what happened.

As we have been learning about what happened through these different steps and approaches, we are also grateful for more than 900 members of the public who shared their experiences of the mass casualty with us through an online survey. Your contributions helped to build our understanding of the broad impacts of these events.

Before I finish, let me say that it remains a very great honour to be serving as a Commissioner on this inquiry alongside Commissioners Fitch and Stanton. We did not take on this responsibility lightly and we could never have reached this point in the process without the contributions of so many of you. We do thank you all.

This has been a hard journey. This has been a hard journey for the families. This has been a hard journey for all participants and for everyone involved.

Every day we have been asked to confront the great harm and loss suffered during the mass casualty, and the families, participants, all of us have been asked to face it anew. Given this, throughout the course of our work, we have stayed focused on wellness and mental health, making sure dedicated team members and resources were available to assist those taking part and that we shared information about how to access wellness support services through our website.

Together, we did this work to honour the memories of all those who were lost and all those who were affected and to help make meaningful change in the future. We now have a solid basis upon which to make meaningful, achievable recommendations.

I know all of you have what it takes to go further and to make sure the coming recommendations are implemented. Together, we can make our communities safer. Thank you all so very much. I will now hand over to Commissioner Stanton. Thank you.

COMMISSIONER STANTON: Thank you, Commissioner MacDonald, and good afternoon, everyone.

Over the course of our work, we have been building layers of understanding. As Commissioner MacDonald has reminded us, the first layer or phase was focused on building a thorough factual foundation. The second phase was to explore how and why things happened as they did.

This involved exploring the related issues set out in our mandate, to make sure we were taking into account how underlying factors such as intimate partner violence and gender-based violence, firearms access, police and service provider responses, structures and processes, and emergency communications, contributed to the mass casualty.

Another way to think about these issues is as root causes, the cultures, values, structures, processes, and systems that need to be understood so we can work out what needs to change, so that the causes, contexts, and circumstances

that gave rise to the mass casualty can be fully addressed.

We used a number of different approaches to explore the related issues.

We engaged independent researchers to prepare 22 Commissioned Reports about the related issues in our mandate, drawing on key government and policy structures, as well as academic research and lessons learned from previous mass casualties. All of the Commissioned Reports, and more than 1,100 documents of supporting research and policy relevant to our mandate, are available on the Commission's website.

Several Commissioned Reports explored different aspects of policing culture and practices. Some focused on aspects of critical incident decision making. Some looked at potential contributing factors to mass casualties, while others explored the connections between gender, violence, poverty, race, and access to institutional supports, as well as the reluctance of some communities to report violence due to profound distrust in public safety institutions.

The Commissioned Reports also provided a framework for our roundtables.

Over the course of proceedings, we held more than 20 roundtables involving over 100 experts and others with relevant experience to share, some of them local, and others bringing Canadian and international perspectives.

Roundtable discussions allowed us to hear from a deep and diverse set of perspectives, knowledge, and experiences, all of it shedding light on those underlying issues, systems, and structures that we need to address. People taking part in the roundtables spoke to a wide range of topics, including policing cultures, structures, and interoperability, emergency alerting, preventing and responding to mass casualties, addressing gender based and intimate partner violence, and strengthening community safety.

We have held other kinds of conversations during public

proceedings too, including small group sessions with people who had related and important experiences to share, and consultations with groups who were differentially impacted, so we could ensure that our recommendations do not inadvertently have a disproportionate or unintended impact on disadvantaged or marginalized groups.

Through the Commissioned Reports, roundtables and various other kinds of discussions, we have built up an extensive understanding of the causes underlying the mass casualty.

There is a Discussion Guide available on the website that you can use to prompt thoughts or conversations about the issues we have explored including, for example, public communication during an emergency, looking into the decision making process for sending a public alert during a mass casualty; technical information about emergency alerting; the design, implementation, capabilities, and limitations of Canada's emergency alerting system, or Alert Ready program; best practices and useful models for emergency communications in other countries; how to convey important information to the general public as well as to first responders at the tactical level and to other emergency responder agencies; and how to share important information from the public in emergencies.

We have looked into supporting individuals, families, first responders, service providers, and communities after a mass casualty, including learning about what worked or did not work for survivors, those most affected and support services of this mass casualty and other mass casualties; considering international experiences with the sharing of information and support following mass casualties; exploring best practices for addressing the needs of those most affected and models that support people through grieving, and that promote healing and foster resiliency; and trying to distill key principles for supporting those most affected, including comprehensive support services that are tailored to meet different needs.

Another issue we have explored is the link between gender-based and intimate partner violence and the mass casualty.

We have heard about the dynamics of violence generally and more specifically gender-based and intimate partner violence as linked to the causes, context, and circumstances of the mass casualty.

We heard about how understanding the dynamics between these forms of violence could assist in the development of policies to better understand, prepare for, identify warning signs for, and respond to mass casualty events; how prioritizing, prevention of these forms of violence as a social and political objective may be a promising strategy for preventing some mass casualties; and the barriers to effective police and other institutional prevention, intervention, and responses to intimate partner violence, gender-based violence and family violence.

We explored issues related to improving community safety and well-being, including best practices for improving community safety that goes beyond crime and policing and includes mental, physical and social well-being; approaches focused on community development and contemporary community policing, coordinated leadership, and enhanced ability to intervene early and employ preventive strategies; police and law enforcement agencies, public service institutions, organizations and systems that are mandated to help keep communities safe; and individual and community opportunities to keep each other safer and to support each other in the future.

We have examined the current structure and approach to policing, including the working culture and organization of policing and law enforcement within Canada and in other countries; police responses to mass casualties, including training, standard operating procedures, equipment, and resources; the need to break down silos of work within police agencies and between police and non-police partner agencies; how numerous Nova Scotian and other Canadian reviews and reports have made recommendations with respect to many issues such as police oversight, training, preparation, and organizational culture; how too often these recommendations remain unimplemented; how assessments of the implementation of past recommendations may

provide an additional perspective into the police context and can identify recurring challenges in achieving reform; and barriers to change and strategies for understanding and overcoming these barriers.

We have explored issues related to firearms access, including policies about how police respond to reports of the possession of prohibited firearms, including communications between law enforcement agencies; the broader context of rural gun ownership and community safety; past recommendations about access to firearms in the context of active shooter events; connections between gender-based and intimate partner violence and firearms; and legal and policy interventions, including firearms registration systems, risk assessment, the limitations of reporting mechanisms when civilians are worried about safety as a result of the acquisition or presence of firearms, and the use of pro-removal policies in situations of intimate partner and family violence.

We have also looked into how the private ownership of police paraphernalia is regulated, including the impact of the perpetrator's police paraphernalia and replica RCMP vehicle in the mass casualty; the current regime for regulating procurement, access, and disposal of police paraphernalia; differing impacts of police symbols; the negative impact of criminal behaviour by police impersonators and its wider impact on trust in police; a range of views on the question of whether the advantages of allowing police uniforms, equipment, and vehicles to circulate in the general population outweigh its risks.

It's a long list of issues and topics, but I assure you, I have just scratched the surface of everything relevant to our mandate that we heard and have learned through the roundtables, Commissioned Reports, resource materials, and other conversations held during public proceedings.

As a public inquiry, we've also invited members of the public to make submissions through our website with suggestions for research or policy that might be relevant to our work. We have received over 200 entries through that process.

Thank you to everyone who made a public submission. You can still submit suggestions for recommendations for change on our website until the end of September.

The April 2020 mass casualty in Nova Scotia was a large, interconnected, and complex critical incident. The perpetrator had also harmed many people in many ways before the mass casualty. The issues underlying these actions are also broad, interconnected, and complex.

If we want to help prevent future mass casualties, we need to address the root causes. This means doing the hard work in our communities, our workplaces, our institutions, and in our legislatures to make lasting and deep changes.

This coming responsibility may seem daunting, but please remember that at its heart, this is really about doing the work required to take care of people, our loved ones and our families; our friends and neighbours and colleagues.

We all want to live in safe communities and it will take all of us to make it happen.

Before I finish, I would just like to say, it's been honour to join with Commissioners MacDonald and Fitch serving the public.

In a moment, Commissioner Fitch will thank the many different groups of people involved in our work in a more comprehensive way.

For my part, to everyone who joined us in our service of the public interest, thank you.

Now Commissioner Fitch will share some concluding remarks.

COMMISSIONER FITCH: Thank you Commissioner Stanton, Commissioner MacDonald, and hello everyone.

This afternoon my fellow Commissioners have reiterated why we are here, how far we have come together, and what we have achieved in our work to understand what happened, and how and why it happened.

Over recent weeks, we have been making progress in the final

phase of our public proceedings, which was all about deepening our understanding with the aim of developing recommendations. I will now share our forward-looking focus and talk about the final report and recommendations.

As we said at the start of this phase, our goal is to develop recommendations that: are built on everything we have learned, are informed by the perspectives of many people with different kinds of expertise and experience, draw on recommendations from earlier inquiries and reports, including an understanding of what has worked and what has prevented progress in the past, recommendations that are clear, pragmatic and implementable so that people across our governments, institutions and communities can begin to take action right away.

To help us develop recommendations like these, we've held roundtables, participant consultations and discussions with those most affected and community members to ensure we are benefiting from a rich and diverse set of perspectives and experiences. We are also encouraging all Canadians and those who are interested from beyond our borders to continue to share ideas for change. Information about how to do that is available on our Commission's website.

As Commissioner Stanton noted, on our website, you can find a discussion guide summarizing the types of issues we are exploring and asking questions to help you think about recommendations. We hope this will encourage and help you discuss potential changes and recommendations with your coworkers, your families, friends and neighbours. Also on our website, you will find the Environmental Scan of Prior Recommendations. This comprehensive document is directly related to our broad mandate. It captures over 2,000 relevant recommendations from earlier public inquiries, reviews, and investigations.

The reviews are grouped according to the research structure developed by the Research and Policy team of the Mass Casualty Commission. This is intended to help identify gaps and opportunities, inspire new recommendations, and also help us all reflect on the barriers that have prevented meaningful change in the

past.

After today, the Commission's public proceedings are over. But I assure you, our work is far from done. While you may not hear from us as often, or see us in our daily proceedings, in the weeks and months ahead, we will be exclusively focused on preparing and completing the Commission's final report, which will be shared publicly by March 31st, 2023.

We will use this time to ensure the final report is completed with the rigour and care, the rigour and care it deserves. As you might expect, the final report will be comprehensive. It needs to be both broad and deep in order to fulfil our mandate, in order to share our detailed findings of what happened, and in order to convey everything we have learned while exploring the underlying causes and issues. The final report, which will be available in both English and French, will include the Commission's recommendations. We will be working hard to make these as clear and effective as possible. We know recommendations alone are not enough and so we will be including guidance about who could, and who should, do what, when, where, and how. This is intended to build in mechanisms to track and hold to account the responsibilities of others going forward.

In this time between the end of proceedings and the release of the final report, we encourage everyone to keep up the many conversations about community safety and wellbeing. We have seen so many examples of groups coming together and having important, valuable conversations. Please keep collaborating and looking for ways to work together and improve.

All of the Foundational Documents, source materials, supplementary reports, Commissioned Reports, research and policy documents, witness testimony, roundtables, and other proceeding webcasts remain available on our website. They are there for you. They are there for you to use and talk about with your communities, your coworkers, within your networks, and with your families.

Our progress has been made possible by the hard work of many

people over the last two years. On behalf of the Commissioners, I would now like to share our unending gratitude. Know that I will never be able to name everyone or make it clear with mere words how thankful we are to each and every one of you.

Starting with the families, thank you for meeting with us early in our work in 2021 and again over the past few weeks and for sharing your thoughts and experiences. We continue to extend our deep and lasting condolences for your losses, and we share your dedication to making our communities safer in their memories.

Thank you to all the participants and your counsel. You have all played a critical role in this inquiry, helping shape our approach, building the factual foundation, taking part in roundtables and other discussions, and sharing your submissions. You have put in long hours outside of proceedings and have been here with us during the many long days and weeks of public proceedings, and we thank you very much for that.

Thank you to all the responders who were first on the scene during the mass casualty. Whether you are with the police, firefighters, emergency health, or other civilian service providers, we appreciate your courage and ongoing commitment to keeping people safe and helping them in times of hardship.

Thank you to the many witnesses and other people we heard from in interviews and during proceedings. We know it remains difficult for many to revisit the days during and after the mass casualty. Your recollections about what happened and perspectives on potential causes and recommendations have been instrumental to our work and we deeply, deeply appreciate it.

Thanks also to the many individuals who took part in the roundtables, small group sessions, consultations and other conversations. You have brought an incredible depth and breadth of expertise and experience to our work, shedding light on large number of issues, and complex issues, and helping us gather lessons learned and potential recommendation, including helping us think about making sure the final recommendations do not have disproportionate or unintended impacts on

disadvantaged or marginalized groups.

Thank you to the community organizations who met with the Commission team and helped us do our work in your communities, providing much needed supports and connecting us with necessary people and information.

Thank you to members of the media who have covered the Commission's progress including public proceedings, helping the broader public stay engaged with our work. Many of you covered the mass casualty as it happened and have been with us daily during proceedings. Independent and principled media is essential in ensuring the accountability of public processes such as ours, and you have done this with dedication and care for those affected.

Thanks also to the many service providers who have helped to make our investigation and proceedings accessible to as many people as possible, assisting us with document management, technology, translation, interpretation, transcription, security, and many other services.

Thanks to the public here in Nova Scotia, in Canada, the United States, and beyond for your engagement and for taking part in our work. We are grateful to those of you who were able to join us in proceedings here in person, those of you who attended the open houses, and all of you who have engaged online, sent us emails, or called.

So far, we have received over 2,000 -- pardon me -- 200,000 unique visitors to the Commission website, and over 350,000 views of our webcasts, and more than 360,000 file downloads, all of this which speaks to strong public engagement.

And finally, thank you to the members of the Commission team, including those of you working on investigations, Commission counsel, research and policy, mental health, our secretariat and logistics, communications, and community engagement. You have worked days and nights and weekends with unflagging dedication and care. And like the rest of the world, you kept going through COVID and

shared in life's challenges as well as celebrations over the last two years, including isolation, illnesses, losses in your own families, weddings, and births. We are so grateful to you and your families too, bringing care and concern for people to everything you have done. We truly could not have done this without your incredible commitment over the last two years.

And thank you to everyone for stepping up. As we work toward completing and sharing the final report, we will call on you once again to keep stepping up.

Community safety is a shared responsibility and a shared opportunity. We can all be, and need to be, champions for change, taking the recommendations and implementing them in our communities, workplaces, and organizations. We have heard commitments from RCMP leaders and other institutional representatives that they will be open to the recommendations and are preparing to receive them. We are encouraged by these comments and commitments, and call on policy makers, institutions, community groups, and members of the public to take action based on the coming recommendations.

In conclusion, I too am honoured to have been asked to contribute and serve the public through this inquiry, and in particular, I've been honoured to serve with our team and alongside Commissioners MacDonald and Stanton. Thank you very much.

We Commissioners have been entrusted with a great responsibility and we will continue to do our utmost to live up to that as we prepare our final report. We call on all of you to live up to that responsibility as well, and to do everything you can to help implement the recommendations, making our communities safer for everyone. Merci beaucoup, and thank you, and travel safe heading out in the storm today.

REGISTRAR DARLENE SUTHERLAND: Thank you. The proceedings are adjourned.

--- Upon adjourning at 12:50 p.m.

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

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

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

Sandrine Marineau-Lupien