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

MASS CASUALTY COMMISSION

Turning the Tide Together

FINAL REPORT OF THE MASS CASUALTY COMMISSION

Executive Summary and Recommendations

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March 2023

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THE JOINT FEDERAL / PROVINCIAL COMMISSION INTO THE APRIL 2020 NOVA SCOTIA MASS CASUALTY

Honourable J. Michael MacDonald
Commissioner, Chair

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

Dr. Kim Stanton
Commissioner

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Executive Summary and Recommendations

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Cette publication est également disponible en français: *Redresser la barre ensemble : Le rapport final de la Commission des pertes massives*. Résumé et recommandations.

This is the Executive Summary and Recommendations of
Turning the Tide Together: Final Report of the Mass Casualty Commission.

The full report is available in English (https://MassCasualtyCommission.ca) and French (https://commissiondespertesmassives.ca) along with transcripts, exhibits, webcasts, and reports prepared by or for the Commission.

Contents

Navigating This Report

Mental Health and Wellness

Sometimes reading about distressing or emotionally overwhelming information can be challenging. As you read this Report, please make sure to keep mental health and wellness in mind. If you or someone you know is in need of support, consider the resources listed below or check with your local health authority or the Canadian Mental Health Association at cmha.ca to find resources in your area. A list of services is also available on the Commission website MassCasualtyCommission.ca.

- If you are experiencing distress or overwhelming emotions at any time, you can call the **Nova Scotia Provincial Crisis Line 24/7 at 1-888-429-8167**. You do not have to be in a crisis to call, and nothing is too big or too small a reason to reach out. The Nova Scotia Provincial Crisis Service can also provide the contacts for other crisis services that are available if you live outside Nova Scotia.
- If you or someone you know is struggling in any way, you can call **211** or visit 211.ca. 211 offers help 24 hours a day in more than one hundred languages and will be able to connect you directly to the right services for your needs.
- The **Kids Help Phone** is a national helpline that provides confidential support at 1-800-668-6868 or Text CONNECT to 686868.
- Additional supports for across Canada are available at www.wellnesstogether.ca.

Report Structure

Turning the Tide Together, the Final Report of the Mass Casualty Commission, brings together everything we have learned about the April 2020 mass casualty in Nova Scotia as well as our recommendations to help make communities safer.

The Report is divided into seven volumes. Volumes that are longer are divided into parts and chapters focusing on specific topics, while others just contain chapters. Recommendations, main findings, and lessons learned are woven throughout the Report and are also listed in the Executive Summary. Please note that quoted material is cited in the Volume in which it appears. Appendices and annexes are also available. All materials relating to the Final Report are available on the Commission website MassCasualtyCommission.ca and through Library and Archives Canada.

Each volume of the Final Report focuses on an area of our mandate:

Volume 1 Context and Purpose

Volume 2 What Happened

Volume 3 Violence

Volume 4 Community

Volume 5 Policing

Volume 6 Implementation – A Shared Responsibility to Act

Volume 7 Process, and Volume 7 Appendices

Annex A: Sample Documents

Annex B: Reports

Annex C: Exhibit List

We hope this Report not only encourages conversations about community safety but also helps people and organizations to move from conversation to collective action. Together we can help to make our communities safer.

Land Acknowledgement*

Pukwelk Skijinukik Ne'po'pni'k nike' Panwijkata'sik.

Wula kmitkinuk tan mena'q iknumwetuk na weskowita'jik wula Panawijqa'tasite'wk.

Anquna'tasik na kmitkinuk wula'tan kisaknutmaqank teluisikel wantoqotik aq witaptultimkewey tan Wapana'kikuwaq mimajuinuk ewi'kmi'tip wla tan qame'kewaq aklasie'wk pekistu'tip 1693ek.

Mu eteknukul tamiaw kisaknutmaqanetuk kisna ankuo'mkeweletuk kisna tplutaqanetuk kluswaqn iknmuetasik kmitkinuk. Nasik mikwaptasikip Wapana'kikuwaq wisunkewey aq kisa'tu'tipn tplutaqank wjit tan tel wela'matultimkewel.

Mej majukwaqtasilkel kiskuk aq nekey wjit wet telwa'tik msit wen na kisaknutamaqank na anquna'luksi'kil.

Nikey, Panwijqa'tasite'wk nenmi'tij tan kis tlitpi'aq ajkneiwaqn wjit mimajuinu'k weskowita'sijik We'kopekitk kmtne'ktuk, Wasoqsikeka'katik, Matuwese'ka'katik, Nisaqaniska'katik, We'kwampekitka'katik, Sikipne'katika'katik, Ene'tekopukwuek, aq Niktuipukwek!

Wula nekey wutank kpme'kl! Ta'hoe!

* This land acknowledgement was prepared at the Commission's request by Tuma Young, KC, member of the Eskasoni and Malagawatch First Nations, co-founder of the Wabanaki Two Spirit Alliance, and assistant professor of Mi'kmaq Studies at Cape Breton University, and was prepared in consultation with Elders. The communities of Glenholme and Debert are in the same general hunting area, so both are referred to as Wasoqsikek (area of bright light). Hunter Road and Wentworth are also in the same general hunting area and are referred to as We'kopkeitk Kmtme'tuk (Cobequid Mountain area).

The Mass Casualty Commission is located on Mi'kma'ki, the unceded territory of the Mi'kmaq People.

This territory is covered by the "Peace and Friendship Treaties" which the Mi'kmaq and the Wabanaki tribes first signed with the British Crown in 1693.

The treaties do not deal with the surrender of lands and resources but in fact recognized Mi'kmaq and Wabanaki tribe's titles and established the rules for what was to be an ongoing relationship between the nations.

These treaties are still recognized and followed to this date by all parties. That is why we say we are all Treaty People.

The Mass Casualty Commission would also like to acknowledge the harm and trauma that has been inflicted on the people in the communities of Hunter Road, Wentworth, Glenholme, Portapique, Debert, Onslow, Truro, Millbrook, Shubenacadie, and Enfield.

This land in which these communities are located is now considered sacred by all.

Ta'hoe!

Message from the Commissioners

In April 2020, in the first weeks of the COVID-19 pandemic, the most lethal mass shooting in Canadian civilian history unfolded over 13 terrible hours in Nova Scotia. A perpetrator shot and killed 22 people, one of whom was expecting a child. Many more people were harmed and affected, across Canada, the United States, and beyond.

On behalf of all Canadians, the governments of Canada and Nova Scotia established the Mass Casualty Commission in October 2020 to determine what happened, how and why it happened, and to set out lessons learned as well as recommendations that could help prevent and respond to similar incidents in the future. After two and a half years of independent and thorough investigation, this Report comprehensively fulfills the Commission's mandate.

Our recommendations are designed with two objectives in mind: prevention of violence and ensuring effective critical incident response by police, other public safety partners, health and victim service providers, and communities. Crucially, we also consider the broader root causes of violence, how such violence can be prevented, and how we can all help to improve community safety and well-being.

There were many warning signs of the perpetrator's violence and missed opportunities to intervene in the years before the mass casualty. There were also gaps and errors in the critical incident response to the mass casualty as it unfolded on April 18 and 19, 2020. Additionally, there were failures in the communications with the public during and in the aftermath of the mass casualty. These issues can be addressed, and responses, including public alerting, can be improved.

The future of the RCMP and of provincial policing requires focused re-evaluation. We need to rethink the role of the police in a wider ecosystem of public safety. Significant changes are needed to address various community safety and well-being

needs of the 21st century. The existing culture of policing must change. Issues around interoperability between emergency responders and other community safety partners, for example, require improvement. Everyday policing practices, policies, supervision, information-sharing, learning, transparency, and accountability require attention across the board, beginning with an overhaul of police education in Canada. As our Report details, there are significant steps that the RCMP, municipal police, and other public safety partners can take to improve prevention, timely intervention, and, when needed, critical incident response. Most important, the RCMP must finally undergo the fundamental change called for in so many previous reports. This transformation must begin with recruiting and education, and from there extend to all aspects of the RCMP's work.

In addition to rethinking policing, it is critically important that we address the root causes of violence. We must acknowledge and address social factors like poverty and inequality because it is clear that the social determinants of health are also the social determinants of community safety. We need to accept that those who perpetrate mass casualties often have unaddressed histories of gender-based, intimate partner, or family violence – which means that tackling those forms of violence must be an urgent priority. Valuing all members of our communities, from childhood onward, will contribute to making our communities safer for everyone.

We must invest in a public safety system that is about more than police services, where multiple partners work together every day with substantial community engagement. Community safety planning needs to take social development, prevention, early intervention, and critical incident response into account. This approach means that public policy and funding should put crime prevention on an equal footing with enforcement. The police should be understood as a *part* of the community safety net. Their important responsibilities to ensure public safety are shared with community members as well as with other organizations and institutions. This collaboration will enable each partner in community safety to focus on the aspects of public safety that best suit their knowledge and expertise.

Across our country, we all have work to do. The Public Inquiry that led to this Report is proof we can work together. This Report, like all the Commission's work, is the result of the contributions of many people, including the families, Participants and their counsel, emergency responders, witnesses, participants in roundtables and other discussions, community organizations, the media, service providers, the public, and the Commission team. Once again, we thank everyone for contributing to this important work. In addition, we acknowledge with gratitude that with our

work in Nova Scotia, we were guests in Mi'kma'ki, the ancestral and unceded territory of the Mi'kmaq.

Turning the tide on the underlying causes of violence in our communities will take courage, commitment, and collaboration. It will take courage to admit that we face a set of interconnected and complex challenges and that we must resist defaulting to the simplistic answers and impulsive responses that have failed us all too often in the past. As a country, we need to commit to persisting month after month, year after year, making steady improvements and sustained efforts to shift entrenched values, fix broken systems, and make violence prevention our guiding star. It will take collaboration from all Canadians – including leaders, policymakers, emergency responders, service providers, public institutions, community groups, and members of the public – to turn the tide. By working together, you helped us to develop meaningful, practical, and sustainable recommendations for the future. Now we call on you to help implement these recommendations, which will contribute to ensuring safer communities for everyone. We all have work to do. It is time to act.

Sincerely,

The Mass Casualty Commission

Hon. J. Michael MacDonald, Chair

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

Dr. Kim Stanton

We remember

Tom Bagley

Kristen Beaton, who was expecting a child

Greg and Jamie Blair

Joy and Peter Bond

Lillian Campbell

Corrie Ellison

Gina Goulet

Dawn and Frank Gulenchyn

Alanna Jenkins and Sean McLeod

Lisa McCully

Heather O'Brien

Jolene Oliver, Aaron Tuck, and Emily Tuck

Constable Heidi Stevenson

E. Joanne Thomas and John Zahl

Joey Webber

Part A: Commemoration

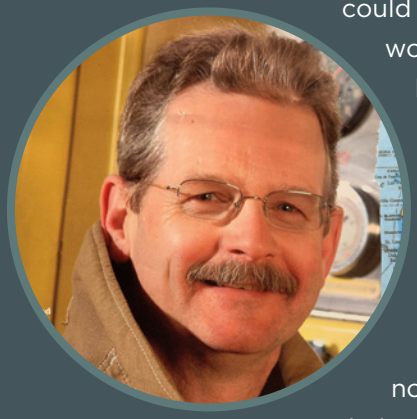
PART A Commemoration

The Commission's work was grounded in the memories of those whose lives were taken. We paused to remember them each day during our public proceedings and carried their names with us while we worked.

No one holds those memories more dear than the families and loved ones of the people we commemorate here. Many of these same family members also took part in the Inquiry as Participants. As Commissioners, we are grateful for the courage they showed in speaking with us about their loss, experiences, and suggestions for change. We continue to extend our deep and lasting condolences to them.

We asked all the families if they would like to commemorate their loved ones in their own words. In the pages that follow, we set out the memories and the pictures they chose to share with us.

Tom Bagley



Tom Bagley was a man who wore many hats. Not only was he a devoted husband to wife Patsy Bagley for almost 50 years, he was the best father that anyone could dream of. I was so truly blessed to be able to call him dad. My world feels so much smaller now without him in it. The title that he most loved in later years would most likely be Poppy. It was the way his blue eyes would sparkle the moment you said the names Brody and Braea that made it quite obvious there was a special bond that will forever be cherished.

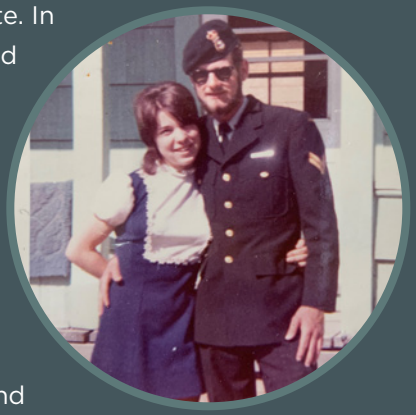
Tom was born April 21, 1949 in St. John, New Brunswick to parents Edward and Eileen Bagley. He was one of four siblings: Jim Bagley, Mary Bagley Creighton, and Richard Bagley, now deceased. Tom knew from a young age that he wanted to help others. At 15 he enlisted in the reserves and continued until the age of 17 at which time he began his life's adventure with the Royal Canadian Navy RCN/CAF as a leading Seaman, where he served for 10 years on such ships as HMCS Saint Laurent, the HMCS Margaree, and the ship that he was the most passionate about the HMCS Bonaventure. After leaving the Navy, Tom began his career as a crash rescue firefighter at the Halifax International Airport (HIAA) for 31 years. During this time he also volunteered at both the Enfield Volunteer Firehall and Elmsdale Volunteer Firehall for approximately 20 years of service.

In addition to volunteering, Tom was involved in many different organizations. He was a third-degree knight with the Knights of Columbus Saint Bernard's Council 11625 in Enfield. In honour of his passing an annual award entitled the 'leave no neighbour behind' is given to someone in recognition of going above and beyond to assist a neighbour or community member in need. It is my opinion my dad exemplified this on that fateful day. Tom was also a member of the Lions Club for many years, volunteering his time in the community.

Tom loved just being out in nature. He loved fishing, hunting, skidooing, driving his ATV and going for rides on his Harley. Tom was an avid Harley lover and was a life-time member of the Harley owners group. Tom sat as Atlantic Director and regional Director for a number of years. Tom was also a member of the Snowmobilers Association of Nova Scotia (SANS).

Tom was the type of person who was never at a loss for words. He definitely could talk. He was an earnest story-teller who could keep people captivated until the very end. He had a wealth of knowledge that now is sadly lost. What I wouldn't give to hear one of his stories one last time.

After his passing while going through some paperwork, I came across a certificate from the Canadian Red Cross blood collection acknowledging that he had donated over 100 times. I recall as a child many times hearing the phone ring, asking if my father was available to donate his O negative blood. It was only in recent years due to health restrictions that he was no longer able to donate. In the wake of this devastation, the Canadian Red Cross launched a campaign to encourage people to donate blood. I knew this was something near and dear to my father's heart and something he would stand behind. I contacted the Red Cross and shared that my dad was a faithful donor and as a result the campaign to donate in my father's name was decided. To those of you who donated and continue to do so, thank you.



My dad was a man who lived to help others, and despite this noble quality that led to his untimely death, I am certain he would have done the same over again as that was the type of man he was. He was my hero and my pride. It is my hope that we all remember Tom Bagley by the way he lived his life and not by the tragedy that ended it.

Contributed by Charlene Bagley on behalf of the family of Tom Bagley

Kristen Beaton, who was expecting a child

Photo contributed by the family of Kristen Beaton

Greg and Jamie Blair

Photos contributed by the family of Greg and Jamie Blair

Joy and Peter Bond

When Harry and Cory Bond remember their parents, they recall seeing their Mom and Dad happily climbing into a big rig together and driving off into the sunset alongside a cloud of black smoke.

"Soft hearted and kind people, they were just good people," said the younger brother Cory.

Growing up in Back Bay, New Brunswick, Joy worked at the local sardine plant. One day she saw a truck driver waiting by himself to unload a delivery. She offered him dinner while he waited, which led to a marriage spanning more than four decades.

As a stay-at-home mom, Joy was always there when you needed something. She was well known for her pumpkin and lemon meringue pies, banana bread and classic Maritime turkey dinner.

Her daughter-in-law Patty remembered, "You could ask Joy for any recipe or how to substitute an ingredient while cooking." Joy also enjoyed crocheting blankets and dishcloths for friends and family. Her sons described her as someone who animals and children instantly loved. When she would come to visit Harry and Patty Bond's house, she would take off her glasses so that Cooper, one of their four beagles, could lick her face until she would snort from laughing so hard. Each year, Joy decorated her home with beautiful and elaborate Christmas villages that continued to grow larger and larger each holiday season.

At 74 years of age, Peter was a retired truck driver, and a legendary one at that. He had his Class 1 license and could drive just about anything on wheels whether that be a school bus, garbage truck, 10 wheeler or 18 wheel tractor trailer. Working independently while on the road, Peter was joyful behind the wheel and often reported that "his 18 wheeler was his therapy". Both Harry and Cory remembered taking long distance hauls into the United States with their father as far as South Carolina and Georgia. On the road they would drive for long stretches over several weeks without a single disagreement or argument.

As much as he loved to drive, he loved being with his family even more. The family of four would take road trips together to visit Joy's family in New Brunswick and further into New Hampshire in their brand new Dodge Caravan that Peter had won on an Atlantic Lottery scratch ticket.

After raising their two sons near Chester, Nova Scotia, Joy and Peter moved to their retirement home in Portapique in 2007. Their grandchildren, Tessa, Tiffany, Ricky and Kyle, and great grandchildren, Isabella and Sophie, basked in their love and called them Nanny Joy and Poppy Peter.

After several decades of being apart for long stretches of time, they grew even closer in retirement, able to spend more time in the same place. They did everything together.

"They went everywhere together, pulling big loads for their family. To me that's old school love," said Harry. "They deserve to be remembered."

That's why he organized a Memorial Drive to honour his parents' memory and all the loved ones lost in the mass casualty from Chester to Peggy's Cove, a scenic, peaceful route along the coast of Nova Scotia's South Shore. Remembering that their Dad insisted that he and Cory say the Lord's Prayer before going to sleep as kids, the drive was started with that blessing for safe travel.

With more than 250 vehicles – motorcycles, jeeps, trucks and big rigs – taking part during the Covid pandemic, Harry led the procession on his first Harley-Davidson motorcycle carrying his 17 year old niece, Tessa, and an urn that contained his parents' ashes.

Harry takes inspiration from his favourite quote from Sylvester Stallone playing Rocky Balboa: "You, me, or nobody is gonna hit as hard as life. But it ain't about how hard ya hit. It's about how hard you can get hit and keep moving forward."

Prepared on behalf of the family of Joy and Peter Bond

Lillian Campbell

Photo contributed by the family of Lillian Campbell

Corrie Ellison

When his family and friends speak about him, they remember Corrie Robert Ellison as a thoughtful, kind person who went out of his way to help others. Ashley Fennell, a close friend of Corrie's for almost a decade, described him as a "beautiful soul".

"My brother was a really good guy. He helped people that he could," said Clinton Ellison, Corrie's older brother.

Corrie was born June 5, 1977 and grew up in the Truro area. While attending Princess Margaret Rose Elementary School, Corrie suggested the school mascot be the panda, which it is to this day. As someone who was legally blind, Corrie connected deeply with music. His father remembered that one of Corrie's favourite bands was Metallica.

"He's the type of person who liked fishing and the outdoors," said his father, Richard Ellison. Corrie loved the outdoors and his life touched the hearts of many people. He was witty and intelligent, and had friends far and wide, many of whom were from the Indigenous community of Millbrook.

Corrie also liked archery, shooting sports and NFL football. While his father was a Minnesota Vikings fan and his brother Clinton supported the Baltimore Ravens, Corrie felt a special connection with the New England Patriots because their legendary quarterback Tom Brady was the same age as Corrie.

Corrie and Clinton were visiting their father Richard Ellison in Portapique on April 18, 2020. The three were getting to know each other again after several years of distance and Richard was thankful for the opportunity to reconnect with his sons.

His father Richard remembered, "Corrie was a fine young man who made the best of the circumstances of his life."

Corrie is survived by his father, Richard Ellison, Portapique; brother, Clinton Ellison (Angela), Halifax; son, Connor Reeves. He was predeceased by his mother, Deborah Ann (Kirk) Ellison, who loved him dearly.

Prepared on behalf of the family of Corrie Ellison

Gina Goulet

Gina Yvonne Marie, age 54 of Shubenacadie. On April 19, 2020 Gina was abruptly taken from this world by an act of senseless violence and will be forever missed.

Gina was a vibrant, dynamic woman and a proud mother. Her free spirited independence led her to live a life of fulfilment. Whether she was on the beach in Cuba, on the river bank with her fishing rod, at her cottage with the dogs, spending time with her family, dancing salsa in her living room or enjoying the company of her horse – she always had a smile on her face and gratitude in her heart. She will be remembered for her kindness, generosity and ability to light up a room. Her laughter and zest for life resonated with anyone she met and she has left this world with much more than she ever took from it. Gina was a survivor. She conquered cancer in 2016 and again in January 2020 but never let it define her life. Her experience was only fuel to live with more love and appreciation in her heart. Gina was a denturist for 27 years. Having the ability to literally put smiles on people's faces was one of her greatest and most proud achievements.

Contributed by Amelia Butler on behalf of the family of Gina Goulet

Dawn and Frank Gulenchyn

While living in southern Ontario and planning their retirement, Dawn and Frank Gulenchyn built their dream home in Portapique, Nova Scotia.

The couple lived in the Durham region for more than two decades before moving to Nova Scotia in 2019. Frank had carefully renovated the couple's retirement home in Portapique as Dawn finished up her career of more than 20 years at Hillsdale Terraces long-term care home in Oshawa, Ontario. She is remembered as honest and conscientious and someone who treated the residents as if they were her own family and friends.

"She showed that kindness and respect for them. When she came into the building, her residents were her family. She was like a beam of sunshine," said Spatzie Dublin, Director of Food Services at Hillsdale Terraces.

Their son Ryan Farrington from Trenton, Ontario remembers his parents by wearing a plaid lumber jacket that his stepfather Frank had given him when he showed up for a visit to his parents' Nova Scotian home underdressed for the weather.

"He gave this to me when I came down one year. It's just something, one of the only things I have to remember my stepfather by," said Farrington.

Dawn and Frank Gulenchyn are lovingly remembered by their sons, Ryan and Jonathan and daughter, Traceena. They were "Nana and Papa" to their grandchildren: Riley, Nolan, Alyssa, Callie, Ethan, Isabella, Kaylee-Anne, Keagan, Makinlee, Paisley, Casey and late granddaughter, Heaven-Lee.

The family has set up a public Facebook group as a memorial named "In loving memory of Dawn and Frank Gulenchyn" which includes a video made by Dawn and Frank's grandson Riley Farrington.

Prepared on behalf of the family of Dawn Madsen (Gulenchyn) and Frank Gulenchyn

Alanna Jenkins

"To know her was to love her".

From the early days of the events of that tragic April weekend in 2020, we have often been reminded of the wonderful, caring and beautiful person our Alanna was to all those that had the honor of knowing her. Through the many stories and memories shared with us from people who had spent time with her, we have even more insight into the amazing woman she had become. Our hearts are full of pride knowing what a difference she made in people's lives!

When asked whether we wanted to have a commemorative page about Alanna in this final report, our immediate answer was yes. We always want her to be remembered for the amazing daughter, sister, granddaughter, niece, partner, stepmom, nana, friend and coworker she was to all! There are many adjectives to describe a person and when talking about Alanna they are endless! Ones that immediately come to mind include:

- Honest & Outspoken – you always knew where you stood with her whether you liked it or wanted to hear what she had to say. If you asked for her opinion you always knew you would get her most honest answer.

- A Great Listener & Loyal Friend – when you told her something you knew it would go no further... as her grandfather used to say "it was in the vault". Together her and Sean were great listeners and loyal friends to all their friends and family. She was the voice of reason that goes along with being a good listener.

- Compassionate & Empathetic – comes from her love for those who mattered most to her and go along with her kind and caring ways. Friends and coworkers often talked about Alanna's energy and positive attitude, her understanding and ability to make things work.

They called her a “difference maker” and they talked about her true teamwork and the tremendous compassion she had for her love of life and family.

Alanna’s involvement with StFX and the Forensic Psychology Program was very near and dear to her heart. She loved helping mentor students and was proud to be part of Forensic Psychology Day at StFX. A former coworker and fellow X Woman said “Alanna always made people feel included and special. She lived her truest self and felt it was okay to just be yourself!”. Although she had a demanding job being a correctional officer and then a correctional manager she was able to balance her work and home life. But most important to Alanna was her love of family and friends.

Our girl was our everything, not only was she our daughter she was our best friend, who we miss every single minute of every single day. She loved her brother, Josh, dearly and could be counted on to support and challenge him only as a sister could.

Her life with Sean at their little piece of heaven on the Hunter Road were her happiest days. They loved their life together whether it was just with themselves or cooking and entertaining family and friends around their table, in the man cave or around a big bonfire... they were the best hosts ever. They loved being out in nature, hunting, fishing, four wheeling, tubing on the river with friends or taking the occasional hike in the woods with their trusty companions Bama and Remi. Their friend Shelly said “They brought out the absolute best in each other and their kindness and giving personalities made you want to always strive to be the best person you could be!”. Alanna (and Sean’s) other happy place was at her Chance Harbour Paradise as she liked to call it, again spending time with family and the beach friends and enjoying beach walks, bonfires and music nights with her being DJ extraordinaire and knowing every word to every song.

With Sean came the family that Alanna learned to love with all her heart. Taylor and Mia, she loved you as if you were her very own and little Ellie brought a happiness to Alanna that was so, so special! From the time Alanna was a young girl she loved children and never lost her desire to find out what would bring joy to a child.

They had so much more love to give and so many more things to experience and places to travel to. We were so, so lucky that our families together shared so many amazing memories with both Alanna and Sean… they just weren't enough. I will steal Alanna's friend Wendy's words "Although Alanna had many qualities that made her exceptional in every way she will be missed most for her loving and giving spirit, her genuine smile, her witty banter and infectious laugh. The light Alanna shone on to all will not be extinguished with her passing. She will live on through those who love and honor her always".

"There is nothing more beautiful than someone who goes out of their way to make life more beautiful for others." – Mandy Hale

These words describe Alanna and Sean to a T and as Alanna herself would say:

"Take the damn picture!"…

And we are so happy she did ♥

Contributed by Susan Jenkins on behalf of the family of Alanna Jenkins

Sean McLeod

"The things you do for yourself are gone, when you are gone. But the things you do for others, remain as your legacy."
- Kalu Ndukwe Kalu

Helping people was something that came naturally to Sean, always the first to lend a hand to someone in need. Offering an ear to listen and support to anyone and everyone needing it, purely out of the goodness of his heart. You never really know how much someone impacts the lives of others, until you hear the stories shared after they have passed away.

To say there was an outpouring amount of grateful stories of Sean, would be a total understatement. He and Alanna both were constantly doing whatever they could to make life a little easier for everyone around them.

On the days he wasn't at work, you could find him outside hunting in his back forty, getting dirty while lobster fishing or just relaxing in the river behind their home. He loved his time in the kitchen cooking and baking everything and anything. Football, of course Tom Brady all the way. You know he made sure to razz all of his buddies about their teams not being as good as his trusty Pats.

You see Sean was one of those people that brought laughter and light into any room he walked into. And it didn't matter where he was, he usually knew at least one person in every room. He could put a smile on anyone's face and it was hard not to just by looking at his cheeky grin and hearing his goofy laugh. Both his best traits that were fortunately passed down to the center of his world, his granddaughter Ellie.

Trying to think what Sean would want to be remembered most for is a hard one because he would say "why would anyone want to remember me anyway?". But each and every person he encountered could tell you something worth remembering about him. The world became dimmer the day we lost Sean, and as cliché as it is to say, the world truly was a better place with him and Alanna in it.

He should still be here to watch his daughters and granddaughters grow up and live their lives. To continue to live his life to the fullest, just like he and Alanna always did. He looked forward to retirement and many more vacations spent relaxing in the sunshine. All things he was robbed of the day we lost him to a senseless and preventable act.

To say Sean is missed, doesn't even begin to describe the loss that all of his loved ones feel. The hole that was left the day he left us is something that will never be whole again, especially without gaining the closure deserved.

We miss you and the joy you and Alanna brought to us and everyone around you Dad, until we meet again someday.

Contributed by Taylor Andrews on behalf of the family of Sean McLeod

Who was Sean Andrew McLeod? This is a question I have been asked and one that is not as simple to answer as you would think. There was so much to him... Sean was a Son, Brother, Father, Godfather, Uncle, Friend and most importantly Grandfather. He was kind, generous, funny, thoughtful, respectful and a jokester, but also could be serious at times. Many people knew Sean but not all of them had the opportunity to know the entire person Sean was. Sean enjoyed being around friends and family having fun, but also loved the quiet solitude his beautiful property in Wentworth provided after a rough day at work. Sean enjoyed hunting, fishing and being out in the wilderness. He also loved being in his kitchen cooking, baking and making preserves. He baked the best fruitcake, keeping up a loved family tradition with our Nan Kavalak's recipe. He loved the Christmas season, when his home was decorated for the holidays it could turn any Grinch into an elf. His yearly Christmas countdown has been missed by many.

Family was very important to Sean, this included his immediate family and also his close friends. He was always available to give a hand to anyone who needed him, whether it be to offer advice or just be an ear to listen. He was someone you could count on and that you wanted to spend time with. At work he was a Leader, a mentor and a confidant to many. He was never afraid to get into the mix and get the job done. He was always fair and treated everyone with equal respect. He was also known to have some fun and stir the pot just a little (a lot). His coworkers were a very important part of his family and a huge support system for him. His mischievous grin is still often part of many conversations. He is very much missed at work.

Sean had the opportunity to spend some much needed quality time with our Mother prior to his passing during her frequent trips to Halifax for medical appointments and also with our Father while accompanying him to his medical appointments in town. With demands of everyday life, sometimes visits to the house were cut short and were not as frequent as they had once been so this was time which they all appreciated very much.

As his Brother, I miss him more than I can express. We all do. The time that we would have had to spend together as a family was robbed from us and that is unforgivable. We do however look back and appreciate all of the time that we did have together and as time passes we relish in the memories we do have. Yes, tears are still shed, but we are now able to tell stories and laugh, look at pictures and smile. He was loved and forever will be.

Was he perfect? None of us are, and that's part of what made him special...

Contributed by Scott McLeod

Lisa McCully

She lived life fully and loved whole heartedly

She was not perfect and embraced her imperfections

She accepted you for who you were and cheered you on wherever you were going.

She was both strength and vulnerability

She was both "go get 'em" and chaos

She was a Sunday school teacher and the friend with the glass of wine

She was a lifelong Berwick United Church Camper and friend to so many

She was the friend who sat with you on the bench and cried with you, dusted you off, and cheered you on

She was the voice on the other end of the phone telling you to keep going, and if you can't, feel free to come over

She was the friend who had depth, spiritually, questions, and curiosity

She was open minded and strived to understand others' perspectives

She was authentic and hopeful

She was brave and adventurous

She was silly and spontaneous

She was "throw it in the car, let's get going, and we'll figure it out when we get there"

She was a friend who was there on the good and bad days

She had more faith than fear

Most of all Lisa was a phenomenal Mom!

Her children were the loves of her life and in her every thought

She would move mountains for them and to leave them would have felt unimaginable.

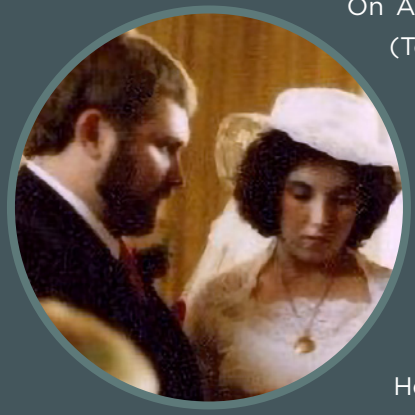
Contributed by Emily Kierstead, Gail MacFarlane, and Ruth Janes on behalf of the family of Lisa McCully

Heather O'Brien

On January 5, 1965 a baby girl was born to Harold and Enid Murray of Masstown, Nova Scotia. She was their first child. Heather Elizabeth. Soon to be followed by two little brothers and a little sister. Heather was kind, intelligent and witty. She was a great role model for her siblings and a daughter her parents could really be proud of. You could often find Heather in the barn. She loved her horses dearly. Her love for guitar also started at a young age. Learning to play by ear as a teenager, she could pick up a song almost instantly. In her adult life, one her favourite pastimes was playing the guitar around the bonfire at any family gathering or barbecue.

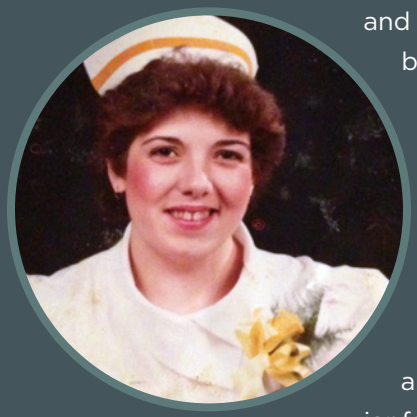
Heather grew up on a small hobby farm in the 70s and 80s before she left the small rural town for education in 1983. Nursing was second nature to Heather. From the moment she put the first uniform on it was like she knew exactly where she was supposed to be, helping people, and she had a knack for it. She started her nursing career in Truro in the mid 1980s. She possessed a warmth and patience that could never be taught in school.

On August 17, 1984, Heather married Andrew (Teddy) O'Brien. The love of her life. If you asked her about her marriage, she would tell you that there were trying times, but her heart always remained with one man. They had a once in a lifetime kind of bond. They were best friends even in the rough times and raised a beautiful family throughout their lives together. They eventually moved back to the same property where Heather grew up, and raised their growing family.



Heather became a mother at the age of 21. Andrew Jr. was her pride and joy and soon after his birth she and Teddy decided that a large family was something they both really wanted. This prompted her to take time off from her nursing career to be a homemaker. She went on to give birth to four daughters. Kathleen, Darcy, Molly and Michaella. Her home was happy and full. A beautiful chaos would be the best way to describe life in the O'Brien

house. She had a soft spot for youth and her home became a safe space for many young people over the years. Everyone had a home at Heather's. With a blustering full house, Heather went on to mother three more children. Logan, Kelly, and Neil brought so much joy to her life. She often spoke of how blessed she was to have the family that she did and taught her children to stand up for what was right and protect their own. One can only assume this is why the family stays incredibly close to this day. Heather returned to nursing in 2003 when she went to work with the Victorian Order of Nurses (VON). She would spend the remainder of her career with the VON. Her love for community through her career was evident. She often spent time with clients in the community she grew up in and this was very special for them and for her. She was a familiar face; most of her clients had watched her grow up and now she would care for them through their retirement years. She considered the nurses she worked with like a second family and often celebrated their successes.



Heather stayed active in her community. She loved to play crib on Monday nights at the local Legion and spend time with her 12 grandchildren on the weekends. Every one of them had a special place in Grammies heart and she was her best self when they were around. She wore the title of Grandmother very well, like nothing else mattered.

Heather O'Brien lived a life that was full, she had what many people strive for in this life and her family finds peace in the fact that she was so happily content when her life was tragically taken on April 19, 2020. Heather's legacy will live in on through her children and grandchildren. They would like the world to remember her for the life she lived and not for the way she died. Though her death has been very public, it is not what defined her. She is defined by her caring and kind spirit, the way she always rooted for the underdog and how beautifully she swept through this life. Though her life was cut short, she certainly lived her life to the fullest and believed in the good that is left in this world.

Contributed by Darcy Dobson on behalf of the family of Heather O'Brien

Jolene Oliver, Emily Tuck, and Aaron Tuck

JOLENE OLIVER

Jolene Lori Oliver was born into a family full of love on November 25, 1980, in Calgary, Alberta. She was the youngest of John and Bonnie Oliver's three daughters, the adored baby of the family and "beyond spoiled" according to her family. She was a very tiny baby – she wore doll clothes for the first six months of her life – and quickly earned the nickname Teenie Weenie Little Joleney.

Jolene was the cutest child. She had natural curly hair, a happy-go-lucky attitude, a constant smile and a remarkable little giggle. As she got older, that giggle turned into an infectious laugh – when she laughed, everyone laughed.

Jolene spent most weekends camping with her family as she grew up. She was passionate about nature from a young age – except for the kind of nature that includes spiders – and particularly loved birds, butterflies, dragonflies, pansies and roses. She would become an avid bird watcher later in life.

Jolene loved writing poetry. And her favourite time of the year was always Christmas. She was born 30 days before Christmas and made sure you knew that Christmas was right around the corner every year on her birthday.

In her elementary school years, Jolene was often sick and spent quite a bit of time in the hospital. It was through this that she realized how many people really cared about her and how much others often did for her. As a result, from a very young age she learned to find joy in doing things for others.

As is often the case in families with three siblings, Jolene was frequently teased by her two older siblings, Crystal and Tammy. They would intentionally push her food together because she hated for it to touch and would happily chase her around the house with a rubber egg pretending that they were about to crack it on her (they only would use a real egg occasionally). Sometimes they would make her very "special" drinks from questionable ingredients found around the house, which Jolene would eagerly drink to have the chance to impress her sisters.

Despite the teasing, Crystal, the eldest of the three girls, quickly became the keeper of her two younger sisters and was always very protective of them. And Tammy and Jolene would play together all the time.

Family was everything to the Olivers, who lived their day-to-day lives as a tight-knit family, spending quality time together. Jolene never missed a birthday or holiday and always bought or sent small gifts for people to let them know she was thinking of them.

Crystal shared this about her family:

"No matter what ever happened in life, where we were or what was going on, we were raised that we always had home. There was always a place for us. And it was always safe. We always protected each other and were always there for each other."

Jolene was loved dearly by her family and was the "light of all of their lives". She always had a smile on her face, regardless of life's challenges. She had the ability to find the positive in all situations and in everyone. She was a very loving person who got personal satisfaction out of helping others and making others smile. She often organized gatherings and made the extra effort to stay connected with family and friends across Canada.

Jolene served as a career waitress and loved connecting with people in her community. She was that kind of waitress that people felt was part of the family at meals. She was kind and positive and always there for people.

Her sister Tammy added this about Jolene:

"Jolene was very kind to a lot of people. She was a great listener. She would spend the time with people, listen to their stories and try to help them out. She would lend an ear and take that time that people needed, and I think that really echoed in Nova Scotia."

Soon after Jolene graduated in 1999, she met the love of her life while working at a bar in her early 20s. It was 2000.

AARON TUCK

Aaron Todd Tuck was born on August 16, 1974, in Halifax, Nova Scotia. He was raised by Bruce Tuck and Gloria Rodgers (née Mae), who loved him until their deaths in 2016 and February 2020, respectively.

Aaron had a very special bond with his mother. Gloria would often say that Aaron was the love of her life and her whole world. Aaron, in return, cherished his mother.

As a young man, Aaron was thoughtful and caring. He didn't have much growing up, and as a result of witnessing the kindness people afforded him and his family, he became a person who helped people all the time.

If someone was stuck on the side of the road, he would spend hours outside in the rain with them trying to help them out. While Aaron could be a little rough around the edges, once you got to truly know him, you would quickly see that he had a big heart and was very soft inside. He was caring, loving and very helpful; he would do what he could for anyone.

Aaron's mother remarried to Angus Rodgers. Angus ignited a love of mechanics in Aaron, which would become not only his future career but also one of his greatest passions. Angus was a father-figure to Aaron. "He gave him some real life-lessons and was a big part of his life. Aaron learned more than just mechanics from Angus – he learned to be a man. And how to treat people," said Aaron's mother-in-law Bonnie.

Aaron had a lifelong love for restoring older cars and became an accomplished mechanic. His mechanical mind also allowed him to learn things quickly; he would catch on instantly once shown how to do something.

He was known to spend time making gifts for people, including beautiful leather-work later in life. "The gifts didn't cost anything, just a whole bunch of time and love," said Bonnie.

Always up for an adventure, when Aaron was in his late teens he traveled across Canada with his best friend Jason, who was like a brother to him. They moved all the way to British Columbia together, but ultimately ended up in Alberta.

And it was a few years later in Alberta that Aaron would meet the love of his life in a bar. It was 2000.

JOLENE AND AARON

Jolene and Aaron met in 2000 in Calgary, Alberta. Jolene was a waitress and Aaron was one of her regular customers. They dated for several months before Jolene brought Aaron home to meet her close-knit family because she wanted to be sure that he was the one. "And then that story was written," remembers Jolene's sister Crystal.

Jolene and Aaron loved each other even though they came from very different backgrounds. While Aaron presented a hard exterior, Jolene saw all the good inside him, and through her love, he became a softer person. Aaron was raised an only child while Jolene was the youngest of three in a family that spent much of their time together.

It took Aaron a while to get used to the family dynamic. He didn't understand the closeness of Jolene's family at the start. "But at the end of the day, we all grew on Aaron, and Aaron grew on us," said Jolene's sister Tammy. "And sometimes we agreed to disagree, but we always loved each other," laughed Jolene's mother Bonnie.

As the years went by, Aaron came to really enjoy having a big family and appreciated all the unconditional love that was offered – even if it came with a fair amount of teasing. Aaron and Jolene shared so much in life, and it turned out that one of the things they shared was their fear of spiders. Because of Aaron's tough exterior, it hadn't occurred to anyone in the family that Aaron was afraid of much of anything until one summer night when he launched across the yard screaming and freaking out because a spider had descended from a tree above him. A situation that of course had the whole family rolling on the ground laughing at him. On another occasion, Aaron ran into the house hollering because bats were flying around. "It was funny to see that different side of him. It's not a side of him that he let others see very often," said Jolene's sister Tammy.

Aaron worked for a time at his father-in-law John's glass business, where he excelled due to his ability to learn quickly and apply his mechanical mind. Aaron and John developed a good relationship and Aaron would call John on a regular basis looking for help on repairs around the house or other fatherly advice. When it came to relationship advice though, Aaron's mother-in-law was always the first person he'd call as she knew Jolene so well.

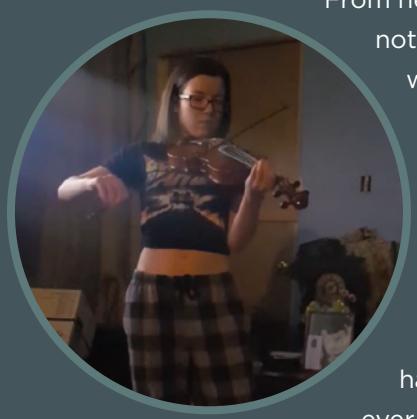
When Jolene was pregnant with Emily and weeks away from giving birth, Crystal remembers being shocked by Jolene's size. She fondly remembers calling her "Rolly Polly Molie Jolie" because of the stark contrast from her tininess growing up. It became a joke between the sisters, and throughout the years during their phone calls Crystal would ask if Jolene was "teenie weenie" or "rolly polly".

Jolene and Aaron's love gave them the power to transcend their differences and it was a love that was strong and constant and fun. And it was a love that led to their "greatest accomplishment" together: a beautiful baby girl named Emily.

EMILY TUCK

Emily Mae Tuck was born on October 13, 2002, in Calgary, Alberta. She was the only child of Aaron Tuck and Jolene Oliver and the youngest of all the grandchildren and cousins.

She was a wonderful blend of both her parents.



From her father, Emily was brave, headstrong, and stubborn. She was not afraid to tell you what she liked and didn't like "whether you wanted to hear it or not" laughed her aunt Tammy and Emily "had her own direction right from a very young age," said her other aunt Crystal. Emily had no fear and was always open to try something new.

And from her mother, Emily developed a kind heart and was incredibly selfless. She had a desire to make a difference in people's lives and was very mindful of how others felt. Emily had this likeability that allowed her to make friends easily wherever she went. Emily treasured giving to other people and was loved by all who knew her.

Emily loved her family. And she loved being part of a big family. She was very close with her five cousins and spent a lot of special time with them growing up. The three girls – Sydney, Sara and Emily – were the youngest and very close in age, and always spent all their holidays and summers together. As Emily was an only child, she adored this time together, even though it came with its fair dose of teasing being the youngest. The cousins had frequent sleepovers, playing spies and climbing trees. They would spend hours waiting for a mouse to appear at the door of the mouse house built into a tree stump by their grandma.

Sara shared this favourite memory of her cousin:

"We would go around in grandma's garden and help ourselves to little snacks now and then. One time we went around and took one bite out of every single pepper in the garden and left them all hanging on the vines. Grandma was left to deal with all these half-eaten peppers, thinking some vermin got into them, but it was really just us."

When she was young, Emily was an early riser, often waking up happy and ready to start the day at 5 or 6 a.m. This didn't always work out so well for other family members as she had a very loud voice and never really learned to whisper. Her aunt Crystal would try to get her to use sign language early in the mornings so she didn't wake up the whole house with little success. "When Emily was in the house, there could be all the grandchildren together, but you could always hear Emily's voice over everyone else's," fondly remembered her grandma Bonnie.

Even after Emily moved to Nova Scotia she still corresponded frequently with family and would came back to visit. "When somebody moves away, there's this distance and sometimes people grow apart. That never happened with her – Emily valued her relationship with each member of the family," recalled Bonnie.

Growing up, Emily spent a great deal of time in the garage with her father where she learned about mechanics and often helped him with his projects. As a young teenager she was able to do her own oil changes and change spark plugs. One time when Aaron was helping Emily's grandpa replace a motor, Emily was right there helping her dad. "I have a photo of Emily sitting in the motor bay cleaning wheel wells. She used to help her dad in the garage all the time," proudly recalled her grandpa John Oliver.

Emily's kind heart extended beyond her friends and family. A school teacher from Sydney shared how much of an impact Emily had made on his life. At the end of Emily's final school year in Sydney, her teacher announced that he would be teaching a younger grade the following year. Emily approached him after class and offered to help him by providing her old materials that she had kept from that grade. She brought them in for him, and to this day he

teaches with them in her memory and always tells his students that the materials were handed down to him by a wonderful young girl that is no longer with us.

Emily had a passion for playing the fiddle. Her father Aaron bought her first fiddle when she was only about four or five years old. Being from Nova Scotia, Aaron would often listen to Celtic music with Emily's grandma Bonnie who was born in Nova Scotia. "If you're from Nova Scotia, you can leave at an early age, but it will never leave you," said Bonnie. The music bonded Aaron and Bonnie, and as there is a lot of fiddling in the Celtic music from Nova Scotia, Aaron always said "as soon as Emily is old enough, I'm going to get her a fiddle" – which is exactly what he did. Emily took to that fiddle immediately and had natural talent. Her older cousin Ricky shared her love for music and they found every opportunity to play music together. Playing the fiddle became her passion. It was after her grandma's encouragement that Emily's father recorded her playing for an online kitchen-party group in late March 2020.

Emily was just a couple of months shy of high school graduation when her life was taken, and she was deciding whether she wanted to pursue a career in music or apprentice as a welder. She was a bright light to her family and to those who had the pleasure of crossing paths with her.

Emily's grandmother Bonnie Oliver had this to say about her granddaughter:

"Jolene and Aaron's greatest accomplishment was their daughter Emily. She was just a very special little girl. I think now she was born to be an angel."

DEEPLY LOVING FAMILY

Aaron, Jolene and Emily meant the world to one another. They were a deeply loving family that did everything together. They shared in each other's challenges, successes and happiness. Their lives were rich in love, kindness, adventure and family. And they were always smiling.

"They didn't need to spend money to make memories. They made the best of every situation and worked with what they had and made a great life," said Jolene's sister Tammy. Jolene's other sister Crystal added: "They made things, they created things. When they gave you gifts, the gifts came with so much love. They all had so much love."

Aaron lived his life devoted to his wife and daughter and doted upon them. Jolene's mother Bonnie knew that Jolene and Emily "were the lights of his life – he loved those two girls more than anything." He attended all of Emily's fiddle lessons,

encouraging her always, and loved to hear his daughter play. He had a souped-up Pinto that he planned to give to Emily on her 18th birthday. "He kept rebuilding it because it wasn't perfect. He needed it to be perfect, he needed it to be the best," said Jolene's sister Crystal.

Aaron, Jolene and Emily spent their early years in Calgary, Alberta and their later years in Nova Scotia. They moved to Sydney, Nova Scotia in 2014 when Aaron's mother became ill, and then to Portapique in 2018 when they inherited the family home. Due to COVID-19 isolation protocols, Aaron, Jolene and Emily spent their final weeks together as a family, simply enjoying each other's company and having fun.

AN ENTIRE FAMILY LOST

"A whole branch of our family tree just got cut off and is no longer there. There's nothing left. It's not like they left any children. They didn't leave anything on this earth. It's all gone. Other than the pieces and tangible things that are left from their memories."
– Jolene's sister Tammy

"It left a big hole in our hearts – we must live every day without all three of them. Why did all three of them leave us at the same time? But they were such a close-knit family. They lived their life together. They made their life together. They had their challenges together. They loved each other. They left this world together. They went to heaven and became angels together. And that gives me comfort, that they are all still together. That's the only way I can rationalize them leaving such a big hole in all our lives – is that they are all still together. Even though we miss our three angels every minute of every day. And we will forever."
– Jolene's mother Bonnie

Prepared on behalf of the family of Jolene Oliver, Aaron Tuck, and Emily Tuck

The day I met Aaron I became whole. I always knew, intuitively, that I had a brother. I don't know how I knew, I just did.

I found out I was right when I was 12 years old, and I found Aaron when I was 16 and he was 19. I woke up on October 16, 1993, went to the library, looked him up in the phone book and called him. My call woke him up. Once I had confirmed that I had the right Aaron Tuck I asked if he knew who I was and he said, "It's my fucking sister!"

I can still hear his voice and those words in my head. I always will.

Life changed for both of us that day. Neither of us had any real support growing up and neither of us had any siblings. We clung to each other immediately and anyone who knew us knew we had an unbreakable bond.

Over the 27 years we loved each other, we both moved around the country but stayed very close. There was never more than a few days that went by that we did not talk on the phone.

When Emily was born, I got a package in the mail with photos of this beautiful baby with big chubby cheeks and Aaron was so proud. As Emily grew, she and I became close. When she learned to play the fiddle, Aaron would call me and she would play for me over the phone. When I had my daughter, she and Emily were each other's favourite cousin and they spent hours together playing and building forts whenever we visited. I have some wonderful homemade birthday cards that she made for me, and I cherish them so much.

Jolene was a strong, kind woman who loved Aaron with all her heart and was like a sister to me. She gave great advice and I spoke to her on the phone as much as I talked to Aaron.

Aaron was a no-nonsense kind of guy who, if you didn't know him, could seem like a jerk because of his directness and gruff voice. But to those who knew him, he was a fierce friend who was reliable and loving. When he hugged me, he wrapped his whole body around me, and I felt safer than I ever felt in my entire life. He was my big brother and in my mind he was indestructible.

My daughter and I lost an entire branch of our family tree that day and we will never be the same. If the tables were turned and my family was murdered, he would never stop fighting for answers and neither will I. I love you Aaron.

Contributed by Tara Long

Cst. Heidi Stevenson

Photo contributed by the family of Cst. Heidi Stevenson

E. Joanne Thomas and John Zahl

Elizabeth Joanne Thomas and John Joseph Zahl moved to Portapique, Nova Scotia in January, 2017 after purchasing their dream home on the Bay of Fundy. Joanne retired early from a career in health services. John was a United States Navy Veteran. He served his country as a Russian Linguist. John retired from Federal Express.

John and Joanne were married for 34 years and truly loved each other. They celebrated every success in life together and worked through all life's challenges together. The strength of their love for each other was evident to all those lucky enough to know them.

John and Joanne loved animals and considered them part of the family. They were generous with animal rescue efforts and programs. They adopted many four legged family members over the years. John and Joanne were sharing their home with Freddie and Zed, the family cats, on April 18, 2020.

John and Joanne believed all individuals were important. They did not ask for help but were willing to help others to a fault. There are so many examples of this, a few are: John worked with troubled youth in Albuquerque Public Schools following his retirement. They both were active in multiple projects for the homeless in Albuquerque and Nova Scotia. They became involved in their community in Nova Scotia upon their arrival. They looked for ways to improve the lives of others. John and Joanne were instrumental in revitalizing the laundry project at their church in Truro, Nova Scotia. They made the project more than a place for the homeless to do their laundry. John and Joanne ensured those using the service had home baked treats, good conversation and that they knew others cared about them. Joanne served as a Board Member for T.R.E.Y. (Trauma Recovery for Exploited Youth).

John and Joanne loved to travel and were always making new friends on their trips whether the trip was down the road to the store or across the world on a cruise. John and Joanne did their best to ensure their family and friends knew they were loved.

John and Joanne are loved beyond words. They are missed beyond measure - EVERY DAY.

Contributed by Jennifer Zahl Bruland on behalf of the family of E. Joanne Thomas and John Zahl

Joseph Webber

Joseph "Joe" Webber was a country boy through and through. He had a kind heart and was a good, hardworking person who never hesitated to lend a hand. Tragically, he died helping others when he pulled over on the highway on April 19, 2020.

Joe was born on October 1, 1983 in Wyse's Corner, Nova Scotia. He grew up with his parents and younger sister Laura. Joe and Laura often played together outside their family home – Joe always with a big smile on his face. The siblings remained very close throughout Joe's life, speaking daily.

Joe gave so much to all those around him. He was well-known in his community as someone who was always there for anyone in need and never expected anything in return. Neighbours remember him as a happy-go-lucky person that they never saw angry or upset.

Joe was a true woodsman, like his dad. He genuinely liked working in the woods and couldn't imagine living in town. His father ran a forestry business and often used horses for logging in the woods around their community. Joe started working with horses at a young age. He became a gifted horseman with an innate ability to work with draft horses. Bow hunting was another pursuit he enjoyed, and he was continually honing his skills. In his younger days, Joe loved racing at Scotia Speedworld. He had worked his way up from Thunder and Lightning Class to Hobby Class while always carrying the #75 on his car. He enjoyed the competition and the comradery.

Though he had these other passions in life, nothing was more important to him than his family. He was a doting father and he loved his family immensely. He would do anything for his girls.

Although Joe didn't live to be there for the special event, he left behind one last gift to his family – a beautiful baby daughter born on Christmas day of 2020. Baby "Jo" – his fourth daughter.

Joe will be sadly missed by his four daughters, Jolynn, Emily, Rory and Shirley; partner, Shanda MacLeod; father, Thomas; sister and closest friend, Laura; niece, Allie; nephew, Rylee; numerous aunts, uncles and cousins as well as a wide circle of friends.

He was predeceased by his mother, Shirley Webber; paternal grandparents, Gordon and Laura Webber; maternal grandparents, Eric and Joyce Boutilier.

Prepared on behalf of the family of Joseph Webber

Part B:
The Mass Casualty

PART B: THE MASS CASUALTY

From Saturday evening, April 18, to Sunday morning, April 19, 2020, a perpetrator shot and killed 22 residents of Nova Scotia, one of whom was expecting a child. He also wounded three more people before being killed by RCMP officers in the ensuing manhunt. His 13-hour rampage extended through several communities in the central part of Nova Scotia. In addition to these gun-related deaths and injuries, many other types of harm resulted from the perpetrator's actions.

Please see the pictures and memories that the families of those whose lives were taken chose to share with the Commission, in Part A, Commemoration.

The mass casualty affected a broad range of people, most significantly the families of those whose lives were taken, as well as other individuals, groups, and organizations, including:

- witnesses who were there, saw what was happening, and were in harm's way;
- first responders and service people, including police, emergency health service professionals, firefighters, and others providing front-line services;
- people living in the affected communities whose friends and neighbours were taken and whose sense of community safety was severely affected; and
- many people in Nova Scotia, Canada, the United States, and beyond.

Rural communities much like those affected by the mass casualty are dotted across our country. The many lessons learned in this Inquiry must be understood, actions taken, and recommendations applied. Doing so will better protect the people and places we love, from sprawling rural spaces to First Nations communities to urban centres from coast to coast to coast.

Overview of the Mass Casualty and the Police Response

Volume 2 of the Final Report provides a detailed account of what happened on April 18 and 19, 2020. The next three volumes – Volume 3, Violence; Volume 4, Community; and Volume 5, Policing – supply further facts and analysis of the causes, context, and circumstances of the mass casualty. This overview does not substitute for the information and analysis provided in these volumes. Rather, its purpose is to supply a chronology of the mass casualty, focusing on the perpetrator's actions and on key aspects of the police response, in order to provide the context for the overall work of the Commission as described below.

Although this overview focuses on the perpetrator's actions and on the formal public safety system response to the mass casualty, community members played a crucial role at every stage. Most poignantly, they included Jamie Blair, Lisa McCully, Tom Bagley, Joseph (Joey) Webber, Andrew MacDonald, and others who died or were injured while responding directly to the chaos caused by the perpetrator. They also included, for example, community members who called 911 to offer information about the perpetrator, his disguise, and his whereabouts, and those who shared information directly with RCMP members as they were engaged in the critical incident response. These community members showed courage and selflessness in their efforts to protect others. In Chapter 2 of Volume 2, What Happened, we find that community members played an indispensable role in the response and that this role was not adequately acknowledged by the RCMP.

For a complete understanding of the mass casualty, we urge you to read the Final Report in its entirety.

The What Happened Timeline is a digital tool complementary to the findings in the Final Report. It provides a visual understanding of what was happening during the mass casualty at different times and locations.

The Commission constructed this timeline using the information set out in its Foundational Documents, which summarized the information available to the Commission at the time they were shared with the public. As the Commission's independent investigation continued, additional information may have come to light that augmented or altered the Commission's understanding of the facts.

The Final Report sets out the Commission's authoritative account of the Mass Casualty Commission's findings, lessons learned, and recommendations. If there is information set out in the Final Report that differs in any way from the timeline, the Final Report governs.

The interactive timeline can be found on our website https://masscasualtycommission.ca/whathappened.

Before April 18, 2020

The perpetrator was a white, wealthy male in his early 50s. He was a denturist, with clinics in Dartmouth and Halifax. He lived part of the time in Dartmouth and part of the time in Portapique, where he owned two properties: a well-appointed cottage and a nearby "warehouse" – a large structure that also contained a bar and guest accommodation. He stored many of his possessions at the warehouse.

The perpetrator was raised in a violent home and became a violent man. A cursory overview of his life reveals the long history of violence in his family of origin. He witnessed family violence, including intimate partner violence, at a young age. He was abused by his father, who was also violent to others outside the family. We learned that violence in the perpetrator's family extended back several generations. There is evidence that intergenerational violence in his family affected many of the perpetrator's relatives.

As an adult, the perpetrator developed an alcohol use disorder and was known to become violent when he drank to excess. Beginning as a youth and continuing as an adult, the perpetrator engaged in violent and intimidating behaviour – a pattern that extended to intimate partners, to friends, neighbours, and business associates, and to patients and community members, particularly those who were marginalized. Many people experienced violence and intimidation in their interactions with him, and many others were aware of it.

On several occasions, individuals reported him to the police and other authorities, but only one report resulted in a criminal charge – for assaulting a teenage boy. In 2002, he pled guilty to this charge and was granted a conditional discharge – one of the conditions being that he attend anger management assessment programs

and counselling as directed by his probation officer. The perpetrator also uttered threats to commit violence using firearms against his parents in 2010 and against the police in 2011. Both these threats were reported to the police.

Lisa Banfield was the perpetrator's long-term common law spouse, and she worked for him in his denturist clinic. Over 19 years, their relationship was marked by his violence, coercion, and controlling behaviour toward her. The perpetrator was physically violent with her and threatened her with a firearm on more than one occasion. He also inflicted other forms of abuse, including verbal and emotional abuse and financial control, and was controlling and possessive in his behaviour toward her. Some individuals attempted to intervene in this pattern of violent, abusive, and coercive behaviours. Others stood by and watched him assault her. He frequently threatened to harm her or her family if she left him. On at least one occasion, in 2013, the perpetrator's violence toward Ms. Banfield was reported to the police.

The perpetrator owned at least five firearms at the time of the mass casualty. He did not hold a possession and acquisition licence, so he possessed them illegally. He smuggled three of these firearms into Canada from the United States. He also had significant amounts of ammunition and a hand grenade. He had shown some of these firearms to several individuals, including his family, his neighbours, and members of Ms. Banfield's family. On three occasions, someone reported his possession of firearms to the police.

At the time of the mass casualty, the perpetrator owned four decommissioned police vehicles. He purchased them through GCSurplus, the Government of Canada's online auction site. He then sought out various items to transform one of the decommissioned vehicles into a strikingly accurate replica of an RCMP cruiser. He told many people about the replica RCMP cruiser, and several had seen it in real life or in photographs. The perpetrator possessed several items of RCMP uniform, including a full traditional dress uniform and a general duty uniform shirt, dark blue pants with a yellow stripe, and Stetson hat. He also had various items of police kit, including handcuffs. He acquired these items primarily through friends and family.

The perpetrator was deeply affected by the COVID-19 pandemic. In the weeks before the mass casualty, his denture clinics had been required to close as part of the public health measures that were then in place. He and Ms. Banfield moved from their main residence in Dartmouth to the cottage in Portapique. In the period after the clinic shut down, Ms. Banfield reported that he became "agitated and paranoid" and was not sleeping or eating much. He stockpiled large quantities of food,

gas, and ammunition and withdrew $475,000 from the Canadian Imperial Bank of Commerce (CIBC). His behaviour became erratic and was increasingly concerning to Ms. Banfield.

The Evening of April 18 in Portapique

The mass casualty began before 10:00 pm on April 18, 2020, with the perpetrator's violent assault of Lisa Banfield in the Portapique cottage. Physical evidence found by RCMP investigators corroborates her account.

The perpetrator inflicted serious injuries on Ms. Banfield, including fractures to her ribs and lumbar spine, before setting the cottage on fire and forcing her to accompany him to his nearby warehouse. When she tried to resist him, he took her shoes and threw them into the woods. She attempted to run away, but he used his flashlight to find her and grabbed her again.

Once they were inside the warehouse, the perpetrator handcuffed Ms. Banfield's left hand. He demanded her other hand, but she dropped to the floor and pleaded with him. When she refused to get up, he fired his handgun into the ground on either side of her. He forced her into the back seat of his replica RCMP cruiser and shut the door. The back and front seats of the car were separated by a steel and Plexiglas barrier with a sliding window. As is typical of police vehicles, the rear doors could not be opened from the inside.

Ms. Banfield was trapped inside the back of the car while the perpetrator loaded firearms into the front seat and moved around the warehouse. She was able to pull the single handcuff off her wrist, causing injuries later documented in medical records, open the window in the barrier, and slide through it into the front seat. From there, she opened the driver's door and fled from the warehouse.

Ms. Banfield hid overnight in the woods in Portapique, where she heard and observed things that made her believe the perpetrator was still in the area looking for her. The perpetrator set fire to his warehouse. Both the cottage and the warehouse became fully engulfed in flames that were visible in the surrounding areas.

Within minutes of these events, at approximately 10:00 pm, the perpetrator arrived at the home of his neighbours Greg and Jamie Blair on Orchard Beach Drive. This couple ran a business providing sales, service, and installation of natural gas and propane units in the Truro area. They loved fishing, cooking, the outdoors, and time

Perpetrator's Movements in Portapique, April 18, 2020

1	Before 10:00 pm	Perpetrator assaults Lisa Banfield at the cottage
2	Before 10:00 pm	Perpetrator sets fire to warehouse
3	10:00 pm	Homicides of Greg and Jamie Blair
4	10:08 pm	Homicide of Lisa McCully
5 or 6	Between 10:08 and 10:20 pm	Homicides of Joy and Peter Bond
5 or 6	Between 10:08 and 10:20 pm	Homicides of Jolene Oliver, Aaron Tuck, and Emily Tuck
7	Between 10:20 and 10:25 pm	Homicides of Dawn and Frank Gulenchyn
8	10:26 pm	Perpetrator encounters Andrew and Kate MacDonald
9	Approximately 10:27 pm	Perpetrator at intersection of Portapique Beach Rd. and Orchard Beach Dr.
10	10:28–10:38 pm	Homicides of Joanne Thomas and John Zahl
11	10:38–10:39 pm	Perpetrator travels through trail on lot 287
12	10:40 pm	Homicide of Corrie Ellison
13	Approximately 10:41 pm	Perpetrator proceeds to blueberry field road via Cobequid Crt.
14	Approximately 10:41–10:45 pm	Perpetrator exits onto Brown Loop

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with their family. The perpetrator shot and killed Mr. Blair on the deck of his home. At 10:01 pm, Ms. Blair called 911 and said that her neighbour had shot her husband. She identified the perpetrator by first name and described the replica RCMP cruiser, but explained he was not a police officer. Ms. Blair instructed her two children to hide. While she remained on this phone call and sought to protect her children, the perpetrator entered the Blair residence, shot the family cat and dog, and then killed Ms. Blair. He pulled logs from the woodstove and scattered them across the living room in an apparent attempt to cause the house to catch fire. He also turned on the propane stove and piled items on top of it before leaving the residence. There is no indication he noticed the hiding children.

Within minutes of Jamie Blair's 911 call at 10:01 pm on April 18, police resources and an ambulance were dispatched to Portapique. The information provided to these first responders by the RCMP Operational Communications Centre was incomplete: key details such as the fact that the perpetrator was driving a "fully decked and labelled RCMP" car but was not a police officer were not conveyed. Four uniformed general duty members of the RCMP Bible Hill detachment – Acting Cpl. Stuart Beselt, Cst. Victoria (Vicki) Colford, Cst. Adam Merchant, and Cst. Aaron Patton – proceeded to Portapique in separate vehicles from various locations around Bible Hill. They travelled at high speed using police lights and sirens.

Between 10:05 pm and 10:20 pm on April 18, the perpetrator took the lives of six more people. His precise movements in that 15-minute period are somewhat uncertain, but the following account represents the most likely chronology based on all the evidence obtained by the Commission.

The Blair children continued to hide until smoke forced them to flee their home. They ran to the house next door, where Lisa McCully lived with her children. Ms. McCully was a mother and a teacher at the elementary school in Debert. She enjoyed the quiet of Portapique and spending time outdoors, biking, snowshoeing, and fishing. She was a neighbour of the perpetrator. Before the Blair children arrived at her home, Ms. McCully and one of her two children had noticed the fire across the road at the perpetrator's warehouse and heard the sounds of explosions. Ms. McCully left her home at approximately 10:08 pm to respond to these developments. The perpetrator shot and killed her soon after, most likely while driving south along Orchard Beach Drive after leaving the Blair home. The Blair children arrived at the McCully residence at approximately 10:16 pm, and the McCully children brought them inside the house. The four Blair and McCully children called

911 and remained on the phone with the call-taker until they were evacuated from Portapique more than two hours later.

After the perpetrator killed Ms. McCully, he travelled south in his replica RCMP cruiser to Cobequid Court to the residence of Joy and Peter Bond and the separate residence of Jolene Oliver, Aaron Tuck, and Emily Tuck. After raising their two sons near Chester, Nova Scotia, Joy and Peter Bond moved in 2007 to their retirement home in Portapique. As the parents of 17-year-old Emily, Mr. Tuck and Ms. Oliver moved their family from Alberta to Nova Scotia in 2014. Mr. Tuck was good with his hands and liked restoring cars, while Ms. Oliver loved nature and was known for her infectious laugh. Emily was creative and played the fiddle. They enjoyed spending time together as a family at their house in Portapique. The Bonds and the Oliver / Tucks knew the perpetrator as a neighbour.

The perpetrator shot these five residents inside their respective homes. He did not set fire to either residence. No information is available to determine the order in which he went to the residences on Cobequid Court. We know that Emily Tuck was alive at 10:03 pm, the time she sent her last text message to a friend. Despite receiving calls from concerned family and community members beginning on the morning of April 19, the RCMP did not find these victims until the late afternoon of April 19.

After killing the Bonds and the Oliver / Tucks, the perpetrator retraced his route, driving north on Orchard Beach Drive past his warehouse and the McCully and Blair homes. He arrived at the residence of Dawn and Frank Gulenchyn sometime before 10:25 pm. Before retiring to Nova Scotia from Ontario, the Gulenchyns had carefully renovated their home in Portapique. The perpetrator shot and killed them and set their home on fire.

Andrew and Kate MacDonald lived on Portapique Beach Road. As they were preparing for bed, they observed what appeared to be a massive fire. Concerned, and unsure whether anyone had reported the fire, they got into their car to investigate. On their way, they drove past the Gulenchyn residence and noticed what they believed to be an RCMP cruiser in the driveway. At 10:25 pm, after confirming the location of the fire at the perpetrator's warehouse, Mr. MacDonald called 911. While on the phone, he turned the car around and drove back north on Orchard Beach Drive. They noticed that the kitchen of the Gulenchyn residence was also on fire.

The perpetrator's replica RCMP cruiser was still in the Gulenchyns' driveway, and Mr. MacDonald initially mistook the perpetrator for a police officer. The replica

RCMP cruiser pulled out of the driveway and drew up alongside the MacDonalds' vehicle while they remained on the 911 call. The perpetrator fired two shots at them. Mr. MacDonald was shot in his shoulder, and another bullet grazed his head. He was able to drive away, followed by the perpetrator and a second vehicle later identified as belonging to the Faulkner family. At the intersection, Mr. MacDonald turned north onto Portapique Beach Road and the Faulkners followed them. As the MacDonalds approached Highway 2, they encountered the first RCMP members, who were just arriving at Portapique. The perpetrator turned south down Portapique Beach Road, away from Highway 2 and the responding RCMP members.

Mr. MacDonald knew Acting Cpl. Beselt, the first arriving RCMP member, and they had a brief conversation. Cst. Patton also spoke with the MacDonalds and broadcast information he learned from them, including the short form of the perpetrator's first name, his approximate age and occupation, and the fact he had a car that looked like a police car.

Within 30 minutes of the first fatality in Portapique on April 18, 2020, the RCMP had received three 911 calls about the active shooter situation. Jamie Blair, the Blair and McCully children, and Andrew and Kate MacDonald all identified the perpetrator by first name and provided other identifying characteristics such as that he was a neighbour and a denturist. These callers each said the perpetrator had a police car, but was not a real police officer, or that he had a car that looked exactly like an RCMP car. They provided identifying information, including that the car was white and had RCMP decals on it.

Important information from these 911 calls was not passed on to responding members or captured within the text-based incident logs produced by call-takers and dispatchers. In particular, the RCMP discounted the clear information coming from Portapique community members that the perpetrator was driving a fully marked RCMP vehicle. Priority was placed on determining whether all RCMP vehicles in Nova Scotia were accounted for, to rule out the possibility that any of these vehicles were involved in the critical incident. This investigative step was reasonable, but it led to a false conclusion that the eyewitness accounts were mistaken.

Based on the information Mr. MacDonald provided that the perpetrator was an active shooter, Acting Cpl. Beselt decided that he and Cst. Merchant should begin an Immediate Action Rapid Deployment (IARD) response. The *RCMP Operational Manual* defines IARD as "[t]he swift and immediate deployment of law enforcement resources to an on-going, life threatening situation, where delayed

deployment could otherwise result in grievous bodily harm and/or death to innocent persons."

Acting Cpl. Beselt and Cst. Merchant proceeded south on foot along Portapique Beach Road. They were soon joined by Cst. Patton, also on foot. We refer to these three RCMP members as the IARD responders.

The other responding member from the Bible Hill detachment, Cst. Colford, remained near the intersection of Portapique Beach Road and Highway 2 to prevent the perpetrator from escaping by that route. She also spoke to the MacDonalds as they awaited medical attention. Starting at 10:43 pm, additional RCMP members began to arrive at Portapique. These members attempted to establish a perimeter to prevent the perpetrator from escaping the area.

RCMP policy requires that a scene commander be designated at a critical incident that entails an IARD response, but no one was appointed to fill that role. The absence of a trained scene commander had a significant adverse impact on the RCMP's critical incident response in Portapique.

RCMP policy did not clearly assign supervisory roles and responsibilities for the period before a critical incident commander assumes command of the critical incident response. Uncertainty about these roles and responsibilities was evident from an early stage within the RCMP's response in Portapique.

We find in Volume 2, What Happened, that the RCMP member who held initial command of the critical incident response in Portapique was S/Sgt. Brian Rehill. On the night of April 18, 2020, S/Sgt. Rehill was the risk manager in the RCMP Operational Communications Centre, which was then located in Truro, Nova Scotia. Risk managers are non-commissioned officers with significant operational experience who are available to general duty members to provide supervision and guidance. They work closely with 911 call-takers and dispatchers (civilian employees of the RCMP who also operate within the Operational Communications Centre). Risk managers can monitor incidents by reading the electronic (text-based) incident activity log produced by call-takers and dispatchers and by listening to police radio. RM Rehill (as we call him during his hours on duty on April 18 and 19) began monitoring the Portapique incident after Ms. Blair's 911 call.

RM Rehill was not a trained critical incident commander. At 10:35 pm, when the scale of the incident was becoming apparent to the first-responding members in Portapique, RM Rehill notified the acting district operations officer, Acting Insp. Steven (Steve) Halliday, of the incident. By 10:38 pm, Acting Insp. Halliday,

S/Sgt. Allan (Addie) MacCallum, and S/Sgt. Allan (Al) Carroll had been contacted. In April 2020, these three non-commissioned members were all key members of the supervisory group in the Northeast Nova District, which comprises most of northern Nova Scotia. At 10:42 pm, Acting Insp. Halliday phoned an on-call critical incident commander, S/Sgt. Jeffrey (Jeff) West, who was based in the Halifax area. Supt. Darren Campbell, the support services officer, quickly approved the deployment of the critical incident commander and specialized resources such as the Emergency Response Team (ERT) and Police Dog Service.

RM Rehill remained in command of the RCMP's critical incident response for more than three hours, while also performing his duties as risk manager. After S/Sgt. West was called out, he arranged for a trained scribe, Sgt. Robert (Rob) Lewis, to record his decisions and actions and obtained equipment from RCMP H Division headquarters in Dartmouth. S/Sgt. West and Sgt. Lewis travelled from Dartmouth to Great Village (approximately 10 kilometres east of Portapique), where S/Sgt. West established a critical incident command post in the Great Village fire hall.

Sgt. Andrew (Andy) O'Brien was the operations officer for Bible Hill detachment. He was off duty on April 18. After Acting Cpl. Beselt called to alert him to the serious incident in Portapique, Sgt. O'Brien phoned his supervisor, S/Sgt. Carroll, and informed him he had consumed alcohol and should not attend the scene. His consumption of alcohol was in no way improper – he was off duty and not on call. However, from approximately 10:30 pm on, Sgt. O'Brien participated in the critical incident response in a supervisory capacity, without attending the scene. The RCMP *Code of Conduct* rule about member consumption of alcohol is poorly framed. We conclude in Volume 5, Policing, that the only appropriate standard for RCMP members is that they should have no alcohol or recreational drugs in their system when on duty. A member who has consumed alcohol or recreational drugs should not report for duty or self-deploy.

The RCMP members who responded to the mass casualty had limited knowledge of the Portapique community and geography. It was dark, with few sources of artificial light, and there was smoke in the air. The RCMP members on scene could hear explosions and sounds like gunshots. Acting Cpl. Beselt used the navigation features of his personal cellphone to orient himself and the other IARD responders as they moved through the Portapique subdivision. RCMP-issued cellphones had no data, and therefore no navigation capacity of this kind. The RCMP did not seek out local knowledge about the geography of the area or about alternative routes out of the community.

After the perpetrator turned south on Portapique Beach Road, he travelled past his cottage to the residence of Joanne Thomas and John Zahl, at 293 Portapique Beach Road. Retirees who had come to Portapique from New Mexico in 2017, the couple quickly became involved in local community and charity work. They lived in a home immediately next to property owned by the perpetrator. In Volume 2, we conclude that the perpetrator shot Ms. Thomas and Mr. Zahl before setting their home on fire. Ms. Thomas and Mr. Zahl were killed sometime between 10:28 pm and 10:39 pm.

After leaving the Thomas / Zahl residence, the perpetrator drove his replica RCMP cruiser on a trail through the woods on his property from the southern portion of Portapique Beach Road to his warehouse at 136 Orchard Beach Drive.

Corrie Ellison and Clinton Ellison were visiting their father, Richard Ellison, in Portapique on the evening of April 18. Corrie Ellison grew up in Truro and had many friends in the area. The brothers heard what sounded like a gunshot and stepped outside, from where they could see flames rising above the treeline. Shortly after, Corrie Ellison said he would go to investigate the source of the fire. At 10:36 pm, he phoned his father to say the fire was at 136 Orchard Beach Drive. He used his cellphone to take photographs of the fire.

At approximately 10:40 pm, the perpetrator encountered Corrie Ellison just south of the driveway to the warehouse and fatally shot him. The shots that killed Mr. Ellison were heard and reported by the Blair and McCully children (who remained on their call with 911) and the IARD responders.

Witness accounts provided different and in some aspects conflicting information about the perpetrator's exit from Portapique. We conclude on the basis of all the evidence that the perpetrator left Portapique immediately after killing Corrie Ellison. From that point, he travelled south, to the intersection of Cobequid Court, and turned left to proceed east along Cobequid Court to a dirt track that was known in the community as the blueberry field road – an unmarked, unofficial road that runs alongside a blueberry field and connects Cobequid Court to Brown Loop and ultimately to Highway 2. Using this route, before 10:45 pm, the perpetrator accessed Highway 2 and drove east toward Great Village. His replica RCMP cruiser was captured on a video surveillance camera in Great Village at 10:51 pm.

RM Rehill began giving directions to secure the perimeter at 10:44 pm on April 18, 2020. At this time, he was overtasked. As the sole supervisor on duty, without a scene commander on site in Portapique, he was monitoring the IARD responders,

establishing containment, monitoring information coming into the Operational Communications Centre via 911 calls, and seeking to secure additional resources such as air support.

At 10:44 pm, RM Rehill instructed Cst. Christopher (Chris) Grund, who was driving from Millbrook, to seal off Highway 2 at Hillview Lane, east of Portapique. However, at about the same time, Cst. Jordan Carroll and Cst. Jeff Campbell were also radioing that they were approaching Portapique from the west, and there was evidently confusion about to whom of these responding members RM Rehill was directing his instruction.

At 10:48 pm, Cst. Colford broadcast by police radio the information, provided by Ms. MacDonald, that there might be an alternative route out of Portapique. However, this broadcast was not heard by members then travelling toward the scene, RCMP dispatch, or supervisors who had been engaged by that point.

No containment point was established on Highway 2 east of Portapique until 12:01 am on April 19.

Back in Portapique, after walking south down Portapique Beach Road, the IARD responders went through the woods from Portapique Beach Road to 136 Orchard Beach Drive. The warehouse structure was completely ablaze, emitting intense heat and periodic explosions.

The IARD responders exited the warehouse property onto Orchard Beach Drive. At 10:49:18 pm, they broadcast the discovery of a deceased male, subsequently identified as Corrie Ellison. They then made their way across the street to the McCully residence, where they located the four McCully and Blair children, who were in the home by themselves and on the phone with 911.

The IARD responders advised the children to shelter together in the basement, and then they left the home. They remained outside for a short time to protect the children but, consistent with their training, made the difficult decision to leave them in order to move toward the sounds of ongoing gunshots and explosions. They were hoping by this means to find and contain the perpetrator. In the ensuing hour, the IARD responders periodically returned to check on the children.

Having not heard anything from Corrie Ellison after his call at 10:36 pm, Richard and Clinton Ellison grew worried. Both men left the residence: Richard Ellison walked to the end of the driveway before returning inside, and Clinton Ellison continued north on Orchard Beach Drive. He illuminated his path with a flashlight.

Clinton Ellison approached the perpetrator's warehouse at approximately 10:55 pm. As he did so, he noticed something lying on the ground on the left side of the road. He shone his flashlight to the area and realized it was the body of his brother, Corrie. When he saw another flashlight shining in his direction, he shut off his flashlight and hid in the woods, believing the person holding the flashlight to be the one who had killed his brother.

At 10:55 pm, the IARD responders observed light from a flashlight south of them on Orchard Beach Drive. They suspected this person – later determined to be Clinton Ellison – to be the perpetrator. The members took up defensive positions on the lawn of the McCully residence. Mr. Ellison turned off his flashlight and fled into the woods. The IARD responders began to follow, but, having lost sight of him and concerned about the possibility of ambush in the woods, ended their pursuit.

At this time, the police radio became congested: RCMP members on Highway 2 were working to establish a perimeter, and Cst. Jordan Carroll identified a suspicious vehicle in Five Houses – a community to the west of Portapique on the other side of the Portapique River. RCMP supervisors and responding members failed to observe radio protocols – for example, they did not keep non-urgent radio transmissions to a minimum at the time when the IARD responders believed they had engaged the suspect or answer questions asked by the IARD responders, and multiple supervisors intervened to provide direction at this time. This failure to observe radio protocols contributed to confusion in the overall response and to uncertainty about who had overall command of the critical incident response.

Sometime between 10:55 pm and 10:59 pm, Clinton Ellison was able to contact his father by phone and tell him that Corrie had been shot. At 10:59 pm, right after ending the call with his surviving son, Richard Ellison phoned 911. He reported that fire and explosions were occurring on Orchard Beach Drive and that his older son (Clinton) had just contacted him to say that his younger son, Corrie, had been shot. He said that Clinton's phone had gone dead.

At 10:59:33 pm, the IARD responders broadcast that they had located the body of a female victim – later identified as Lisa McCully – beside the front fence of her residence. They remained near the McCully home for some time to protect the children inside. At approximately 11:15 pm, because they had no further indication of the perpetrator's likely location, the IARD responders stopped actively searching for him.

At 11:10 pm, Operational Communications Centre dispatch supervisor Ms. Jennifer (Jen) MacCallum called the risk manager of J Division (New Brunswick), S/Sgt. Martin Saulnier, to request support from the RCMP Atlantic Region Air Services. RM Saulnier indicated he would inquire about availability and call back. Less than 10 minutes later, RCMP Air Services advised that the helicopter in New Brunswick was "Off Duty Sick" – that is, dismantled for scheduled maintenance. Efforts to secure alternative air support began at this time and continued overnight and in the early morning of April 19.

Also at 11:10 pm on April 18, the perpetrator's replica RCMP cruiser was captured by surveillance footage (later recovered by the RCMP) entering the Debert Business Park. Some witnesses observed the perpetrator's vehicle as he made his way to Debert and after he arrived there.

At 11:16 pm on April 18, Acting Cpl. Beselt radioed from Portapique to ask whether an emergency broadcast could be used to tell residents to shelter in their homes. At that time, the RCMP Operational Communications Centre was using property records to seek to identify and contact Portapique residents – a laborious and ultimately ineffective strategy.

At 11:32 pm on April 18, the RCMP posted its first tweet about the mass casualty. This text was prepared by the Strategic Communications Unit using an existing bank of social media texts and was approved by Sgt. O'Brien. It stated that the RCMP were "responding to a firearms complaint in the #Portapique area (Portapique Beach Rd, Bay Shore Rd and Five Houses Rd.)." The public was "asked to avoid the area and stay in their homes with doors locked at this time." The phrase "responding to a firearms complaint" in no way conveyed the threat presented by the perpetrator at that time. This public communication was the only one issued by the RCMP until 8:02 am on April 19, 2020.

Despite the relative lack of information provided to the public by the RCMP, community members were taking active steps to share information and to assist one another both on scene in Portapique and through social media posts. We learned from community members that messages were being shared as early as 11:00 pm on April 18. These early messages focused on photos of the fires in Portapique, but they also shared information about the large police presence in Portapique.

Acting Insp. Halliday, S/Sgt. Carroll, and S/Sgt. MacCallum each began monitoring RCMP radio communications soon after they were informed of the unfolding incident in Portapique. S/Sgt. Carroll announced that he was on the air at 11:00 pm. By

11:30 pm, these three officers had assembled at the RCMP Bible Hill detachment to prepare for the critical incident commander's arrival. Acting Insp. Halliday decided to leave RM Rehill in the role of interim incident commander so that he (Acting Insp. Halliday) "could focus on the big picture." None of these senior supervisors went to the scene during the evening of April 18.

Shortly before midnight on April 18, two additional responding RCMP members from the Millbrook detachment – Cst. William (Bill) Neil and Cst. Chris Grund – entered Portapique on foot to protect the four children in the McCully home. At 12:25 am they decided that Cst. Grund would use Ms. McCully's car to drive the children to the Great Village fire hall, where a staging (waiting) area had been established for ambulances and other non-police emergency responders. Meanwhile, Cst. Neil stayed at the McCully home with the IARD responders. By this time, members of the Emergency Response Team were en route to Portapique, where they would take over the active response within the hot zone.

Overnight, the critical incident command considered whether to continue to advise community members to shelter in place or to evacuate them from Portapique. At 12:27 am, S/Sgt. West, Acting Insp. Halliday, and S/Sgt. Kevin Surette, the second critical incident commander, who was driving from Yarmouth and did not arrive until 5:40 am, decided to wait for the ERT's arrival in order to set up better containment and "figure out how to clear [the Portapique] area" safely.

While the Operational Communications Centre staff, responding members, and the critical incident command group made sincere efforts to alert residents and safely evacuate them, the evidence shows that at the time of the mass casualty, the RCMP had not prepared for how best to notify community members and execute a large-scale evacuation of civilians from a hot zone while an active threat was in progress.

By approximately 12:30 am, investigators from the Major Crime Unit had arrived at the Bible Hill detachment. They met with Acting Insp. Halliday, who updated them on the current situation, and joined the investigation efforts. However, the information that the MacDonalds had survived an encounter with the perpetrator and were available to provide more information to responders had not been recorded in the RCMP incident log and was not passed along to them. This information did not come to light for several hours.

CIC West Takes Command at 1:19 am

The critical incident commander, S/Sgt. West, took command of the overall response at 1:19 am on April 19, after arriving at the Great Village fire hall and setting up his command post. Once S/Sgt. West was at the command post, he requested that S/Sgt. Carroll, Acting Insp. Halliday, and S/Sgt. MacCallum join him. They did so, arriving between 2:00 am and 2:20 am. Radio and telecommunications and associated personnel also set up at the command post, together with a crisis negotiator who tried to contact the perpetrator. RCMP members were gathering more information about the perpetrator and the situation in Portapique while also endeavouring to understand what had unfolded.

With CIC West now in command of the incident, RM Rehill continued with risk manager duties. However, no formal transfer of knowledge and updates from RM Rehill to CIC West occurred. For example, CIC West and S/Sgt. Surette did not review or direct that an investigator review the 911 recordings to ensure they had all the information from this source. The command group did not review the incident activity logs themselves or seek a full briefing directly from RM Rehill or the staff at the Operational Communications Centre about what information had been shared by community members and what was known about potential witnesses. Nor did the investigators at the Bible Hill detachment take these steps.

The first H Division ERT members arrived on scene in Portapique at 12:34 am on April 19, approximately one hour and 45 minutes after having been called out. The slower-moving tactical armoured vehicle arrived after the other ERT members. At approximately 1:20 am, after the tactical armoured vehicle arrived at Portapique, it was directed by CIC West to respond to 911 callers in Five Houses who reported seeing lights and movement. At 1:31 am, while the ERT members were responding in Five Houses, Richard Ellison called 911 to report that he had just spoken to his son Clinton, who was hiding in the woods near Orchard Beach Drive. A supervisor from the RCMP Operational Communications Centre called Clinton at 1:42 am. She spoke to him at length in an attempt to pinpoint his location.

After clearing the call in Five Houses, H Division ERT members proceeded to Portapique in the tactical armoured vehicle. They entered the community in search of Clinton Ellison just after 2:00 am. The 911 dispatcher coordinated ERT's evacuation of Mr. Ellison. Although ERT had been advised that Mr. Ellison was a witness and was not a suspect, ERT members handcuffed him and put him in the back of the vehicle. He was dismayed that ERT members did not go up the driveway to locate

his brother's body and that his last memory of his dead brother was seeing him while being driven away, handcuffed, in an armoured police vehicle.

The IARD responders and Cst. Neil were evacuated from Portapique in the tactical armoured vehicle at the same time as Mr. Ellison was transported. They drove to the command post in Great Village, where the IARD responders debriefed with Acting Insp. Halliday, S/Sgt. Carroll, and S/Sgt. MacCallum. They explained what they had seen and done in Portapique, including which houses they had visited and where they had observed bodies and fires. During the debrief, at approximately 3:00 am, members at the command post learned that Mr. MacDonald was a surviving eyewitness. Even at this stage, it appears that Ms. MacDonald was not similarly identified. Mr. MacDonald was not interviewed until 5:00 am, two hours after information about him had been provided directly to the command post. Ms. MacDonald was not interviewed until the following day, April 20.

During the overnight period of April 18/19, the RCMP critical incident command failed to make a decision on whether to continue advising Portapique community residents to shelter in place or to evacuate. Rescue-oriented tasks such as finding and evacuating community members or searching for victims who may have been injured but survived were not initiated until the early morning hours, when the command team discussed checking the condition of the residents at the Blair home. Discussions were more focused on securing air support before initiating an evacuation.

During this overnight period, the critical incident command became concerned about Lisa Banfield's situation. Steps were taken to reach Ms. Banfield by phone and to ping her cellphone, in an attempt to locate her. These efforts were unsuccessful – the perpetrator had smashed Ms. Banfield's phone in the initial assault and left it in the burning cottage. The Halifax Regional Police took some steps to locate her at the home she shared with the perpetrator in Dartmouth and at the homes of some of her family members in the Halifax area. These efforts were also unsuccessful because Ms. Banfield was still hiding from the perpetrator in the woods.

The command group's capacity to coordinate members' work on the ground in and around Portapique was hindered by the lack of a scene commander. In addition, the RCMP was not able to track members' locations when they were not logged onto mobile work stations (the computer in RCMP police cruisers) and when they were outside their vehicles. CIC West did not review containment when he took command of the critical incident response. The command group did not realize there was a gap in containment east of Portapique until approximately 5:00 am. At about that time, Acting Insp. Halliday saw a high-quality electronic map of the

Portapique area and noticed that the blueberry field road might be traversable by car. Accordingly, at 4:57 am, the command group moved a police vehicle to the corner of Highway 2 and Brown Loop, to which the blueberry field road connects. Despite this recognition of a gap in the perimeter, the command group did not reconsider its belief that the perpetrator was still in Portapique.

By 6:00 am, when there were no new reports from Portapique of fatalities, injuries, or encounters with the perpetrator, personnel at the RCMP command post considered that he may have died by suicide and that he had taken Lisa Banfield's life. As daylight approached, thoughts turned to transitioning from a critical incident response to a major crime investigation.

In Volume 5, Policing, we explain that critical incident command decisions should involve the consideration of the widest and fullest range of explanations for the information available to the decision-maker, including worst-case scenarios. Contingency plans should be developed based on multiple potential developments, including the most severe or serious possible outcome. These quieter hours during the early hours of April 19 – when the critical incident commander was in place at the command post – provided an opportunity for the RCMP command to take stock, review, and analyze the information they had received from all sources and to consider alternative scenarios. This opportunity was lost.

For example, RCMP commanders believed that the perpetrator was contained in Portapique, and this belief shaped the critical incident response during the overnight period. The command group focused on whether the perpetrator was dead or alive, not on where he was located. Though the fires and sounds of explosions continued into the early hours, as the night wore on the scene in Portapique appeared to quiet down. No one seemed to take into account the fact that the perpetrator was familiar with the Portapique area and likely knowledgeable about local roads and trails.

Two factors contributed to the limited analysis and flawed decision-making that characterized the critical incident response overnight. The first is that the critical incident command structure lacked a dedicated information analyst. No one was assigned the task of reviewing the totality of information and performing an analysis of it. The second was a flawed decision-making process, particularly the failure to consider alternative scenarios based on the information about the replica RCMP cruiser and mounting reports about the perpetrator and his firearms.

The RCMP did not provide additional information to the public overnight.

Early Morning, April 19

At 5:45 am on April 19, video surveillance footage captured the perpetrator's replica RCMP cruiser heading west on Plains Road from the Debert Business Park toward Highway 4. Less than half an hour later, the replica cruiser was captured on video surveillance travelling north on Highway 4 and passing a residence near Folly Lake; at 6:29 am, video surveillance shows the vehicle travelling north on Hunter Road, Wentworth.

Shortly after 6:35 am, the perpetrator arrived at 2328 Hunter Road, the home of Alanna Jenkins and Sean McLeod, both long-time employees of Correctional Service Canada. Ms. Jenkins worked at the Nova Institution for Women in Truro, and Mr. McLeod worked at the Springhill Institution. Mr. McLeod had met the perpetrator through a friend in Portapique, and the couple had socialized with him.

The perpetrator shot one of the family dogs at the residence and entered the home. He spent almost three hours in the Jenkins / McLeod home. Evidence suggests he shot the couple before setting the house on fire. He took Mr. McLeod's wallet

Hunter Road and Plains Road, Wentworth

Map Data | Google, ©2023 CNES / Airbus

from the scene. The house ultimately burned to the ground, destroying forensic evidence that may otherwise have assisted with reconstructing the perpetrator's actions, including the times of death of Alanna Jenkins and Sean McLeod.

At around 6:20 am, Dave Westlake, emergency management coordinator of the Colchester Regional Emergency Management Organization, was contacted by the Nova Scotia Emergency Management Office and asked to set up a comfort centre for Portapique evacuees. Mr. Westlake was told there had been a shooting in Portapique and that the residents still in the area were being evacuated.

At approximately 6:28 am on April 19, Ms. Banfield left the woods and sought help from the first house she came to: Leon Joudrey's residence on Portapique Crescent. Mr. Joudrey let Ms. Banfield inside and, seeing she was shaking and shivering, gave her his coat and sneakers. He handed her his phone, but she was so cold she dropped it. He picked it up and called 911.

Five minutes later, several members of the ERT arrived in the tactical armoured vehicle and transported Ms. Banfield to the head of Portapique Beach Road. One of the ERT members, Cst. Benjamin (Ben) MacLeod, carried out a cursory medical exam and described her as having no visible serious injuries, although she was in a "state of terror" and had a distraught, dishevelled appearance. She was having trouble walking because of lower back pain suffered as a result of the perpetrator's assault on her. Emergency Medical Response Team (EMRT) member Cpl. Duane Ivany assessed Ms. Banfield as moderately hypothermic. He explained that her body was not circulating heat and that this symptom "indicated to me that she was outside for an extended period." In addition to being a trained EMRT responder, Cpl. Ivany had been a member of the Canadian Ski Patrol for approximately seven years. He has a great deal of experience with hypothermia from the work he did in that period.

Ms. Banfield was taken by EMRT members to an Emergency Health Services ambulance staged at the Great Village fire hall. Once the initial medical assessment was complete and before she was transported to hospital, Ms. Banfield was interviewed for 45 minutes by Cst. Terence (Terry) Brown and Cst. David (Dave) Melanson in the back of an ambulance. Cst. Brown led the interview, and he described Ms. Banfield as lying on a stretcher and in visible pain. During the first 15 minutes of this interview, the paramedics assessed and began treating her. She provided additional details to the RCMP members about the perpetrator, and confirmed that he had a fully marked replica RCMP cruiser.

At the time when Ms. Banfield was extracted from Portapique, the command post was still making its strategic decisions on the premise that the perpetrator had likely remained in the Portapique area and was possibly dead. Plans were being made to transition toward scene investigation, and the question of whether to evacuate Portapique residents remained under discussion. Around 7:30 am, the command post received Ms. Banfield's information about the perpetrator's replica police cruiser and, from another source, a photograph of that vehicle. Although some evidence suggests that this information prompted members of the command group to more seriously consider the possibility that the perpetrator had escaped Portapique, they did not make plans for an active manhunt.

By 7:55 am, the command group had confirmed that the perpetrator's replica RCMP cruiser was not among the vehicles found at his properties in Portapique.

Shortly before 8:00 am, Ms. Banfield was transported to the Colchester East Hants Health Centre, where she was assessed in the emergency department and then admitted. She was treated in hospital for five nights and discharged on April 24, 2020.

Most general duty RCMP members scheduled to work the day shift on April 19 began at around 7:00 am. Some shifts were short-staffed because members had self-deployed the previous evening – they had joined in the critical incident response although they were not scheduled to work at that time and without being directed by a supervisor or a dispatcher to do so.

As members started their shifts, the briefings they received from their supervisors, the Operational Communications Centre, and the command post varied and, overall, were unsystematic and insufficient. Most members picked up as much background information as they could glean from monitoring the radio traffic and speaking to colleagues. Many RCMP members explained they were calling other members and listening to the radio, "trying to gather as much information 'cause we weren't getting a whole lot." Some members relied on information they saw on social media or information shared by family. No general instructions were issued by the command post or the risk manager about what information should be shared with oncoming members.

A shift change was also taking place in the RCMP Operational Communications Centre. At 7:00 am on April 19, the risk manager and the Operational Communications Centre were playing an important, but supporting, role in the critical incident response by capturing incoming information about the mass casualty and

arranging resources, including extra responding members, for the command post. The Operational Communications Centre was also responsible for ensuring that other, unrelated calls were being responded to as necessary.

S/Sgt. Bruce Briers took over the role of risk manager from S/Sgt. Brian Rehill at approximately 7:00 am. He had already started gathering information about the ongoing incident at around 6:00 am, and he asked Halifax Regional Police to share any records about the perpetrator. This action yielded new information about the perpetrator's previous interactions with police. Before taking over as risk manager, S/Sgt. Briers also monitored the Colchester radio channel, but he found the incident log being maintained on the RCMP's Computer Integrated Information and Dispatching System too clunky and slow to be of great value.

Call-takers, dispatchers, and supervisors also had a shift change at the same time, and the Operational Communications Centre supervisor, Ms. Jen MacCallum, remained at the centre until around 7:40 am to make sure the incoming shift was properly briefed.

At 8:04 am, a "Be on the Lookout" (BOLO) notice was sent to RCMP members stating that the perpetrator was "potentially using fully marked ford taurus car number 28B11 and could be anywhere in the province." At 8:16 am, RM Briers broadcast a message to all members that "we're looking for potentially a white, fully marked PC, 28-Bravo-11. Please wear your hard body armour the rest of the … duration of your shift today. Just in the event you come across this vehicle."

The second RCMP public communication about the critical incident was released at 8:02 am. The tweet does not mention the replica RCMP cruiser or the possibility that the perpetrator had left the Portapique area:

> Public Communication #2: April 19, 2020 8:02 a.m. Twitter #RCMPNS remains on scene in #Portapique. This is an active shooter situation. Residents in the area, stay inside your homes & lock your doors. Call 911 if there is anyone on your property. You may not see the police but we are there with you. #Portapique.

By 8:33 am on April 19, the Onslow Belmont Fire Brigade hall opened its doors to assist residents who were evacuated from Portapique. At 9:05 am, the Emergency Response Team began carrying out its evacuation plan and directing evacuees to the Onslow fire hall. CIC West broadcast the location of the comfort centre over the Colchester RCMP radio channel.

At 8:44 am, Acting Cpl. Heidi Stevenson of the Enfield RCMP detachment asked the Operational Communications Centre whether a media release describing the perpetrator's replica RCMP cruiser was being released to the public. (Cst. Stevenson was acting corporal to cover this shift.) S/Sgt. MacCallum had a conversation with Ms. Lia Scanlan, the director of the RCMP Strategic Communications Unit, at about 8:45 am in which he confirmed that the replica RCMP cruiser was unaccounted for. He testified that he understood that this information would now be publicly shared.

Ten minutes later, the third tweet was released. It included a photograph of the perpetrator but did not provide information about the replica RCMP cruiser:

> Public Communication #3 April 19, 2020 8:54 a.m. Twitter 51-year-old [perpetrator's name] is the suspect in our active shooter investigation in #Portapique. There are several victims. He is considered armed & dangerous. If you see him, call 911. DO NOT approach. He's described as a white man, bald, 6'2–6'3 with green eyes. [photo attached]

At 9:12 am, a similar social media message was posted by the RCMP on Facebook.

A Department of Natural Resources helicopter joined the RCMP response at 8:45 am.

At 8:50 am, Tom Bagley left his home on foot for his usual morning walk along Hunter Road. Known for his kindness, caring, and skill as a storyteller, Mr. Bagley was a military veteran and retired firefighter. The distance between the Bagley and Jenkins / McLeod homes was about 400 metres. During Mr. Bagley's walk, he passed the Jenkins / McLeod residence and would likely have observed smoke and fire. Sometime before 9:20 am, Mr. Bagley went to the home, presumably seeking to assist or to ascertain whether assistance was needed. He was shot and killed by the perpetrator.

At 9:19 am, Jody MacBurnie called the Oxford RCMP detachment to express concern that he could not get hold of his neighbours Sean McLeod and Alanna Jenkins. The detachment phone line was not staffed at that time, and Mr. MacBurnie's call was put through to 911. Mr. MacBurnie mentioned that Mr. McLeod knew the perpetrator, said he was aware of the events in Portapique, and explained his connection to Greg Blair. The call-taker replied that he would pass along the information and that Mr. MacBurnie might get a call back. This call was not logged on the RCMP's incident activity log, and the information shared by Mr. MacBurnie was not dispatched to the command post or to responding members.

After taking the lives of Alanna Jenkins, Sean McLeod, and Tom Bagley, the perpetrator left 2328 Hunter Road. At 9:23 am, his replica RCMP cruiser was captured on video travelling south on Hunter Road toward Highway 4, approximately 3.7 kilometres south of the McLeod / Jenkins residence. The perpetrator proceeded along Highway 4, where he encountered and shot his next victim, Lillian Campbell.

Around 9:00 am on April 19, Ms. Campbell left her home on Highway 246, in the Wentworth area, for her regular morning walk south on Highway 4 and along Valley Road. Ms. Campbell, who with her husband had retired to Nova Scotia from the Yukon in 2014, enjoyed gardening and day trips to nearby beaches. She was community-minded and loved walking the roads and parks around her home in the Wentworth Valley.

Travelling south on Highway 4, the perpetrator passed Ms. Campbell, then turned the vehicle around and fatally shot her from his replica RCMP cruiser. He turned the car around again and continued south on Highway 4 toward Glenholme.

Mary-Ann and Reginald Jay were Lillian Campbell's neighbours. At 9:30 am, Ms. Jay was sewing upstairs in her home when she heard a gunshot. She looked out the window and saw an RCMP car slowly turning around and heading south, toward Truro. Then she noticed a body lying on the side of the highway. Recognizing the clothing, she realized the person on the ground was Lillian Campbell. She ran outside to the side of the road where Ms. Campbell was lying and concluded her friend was dead. She ran back to her house and called 911 to report the incident. The 911 call was placed at 9:35 am.

Ms. Jay gave her husband a blanket to cover Ms. Campbell's body. As he was doing so, another person, former paramedic Scott Brumwell, arrived at the side of the road. The 911 call-taker advised Ms. Jay that both she and her husband should remain inside their residence. Ms. Jay, unaware of the active shooter situation, responded that it would be inappropriate to leave their neighbour alone on the side of the road.

Despite the potential danger, Mr. Jay and Mr. Brumwell remained on Highway 4 with Ms. Campbell's body until an RCMP member arrived on scene.

The Mid-Morning Pursuit of the Perpetrator

Although the RCMP command group had some pieces of information earlier, it was not until approximately 9:40 am on April 19 that they fully grasped that the perpetrator had escaped Portapique, that he was driving a very realistic replica RCMP cruiser, and that he was killing and threatening community members in the Wentworth and Glenholme areas. What ensued was a scramble on the part of RCMP members to respond to these new incidents.

The responding members were at a disadvantage when the critical incident response, which had been based on a relatively stationary, possibly barricaded, and possibly deceased perpetrator, became a manhunt across Nova Scotia's rural road system. Despite having made some efforts, for example, to account for the perpetrator's vehicles, the command group had not made plans for the possibility that the perpetrator was on the move outside Portapique. This lack of contingency planning persisted even after the command group became aware that the perpetrator's replica RCMP cruiser did not appear to be among the vehicles found in Portapique. RCMP policies and standard training offered relatively little guidance about how best to coordinate a critical incident response to an active mobile threat.

At about 9:42 am, RCMP dispatch broadcast the information from Ms. Jay's 911 call over the Cumberland radio channel, followed quickly, at 9:42:30 am, by the Colchester radio channel. The RCMP Emergency Response Team, Police Dog Service, and general duty members stationed in Portapique and at the Cobequid Pass toll plaza were directed to respond to the Wentworth area. Additional RCMP members responded from their detachments and other locations. The first-responding RCMP members arrived at the location where Ms. Campbell was lying at 10:09 am. They confirmed that she was deceased and contained the scene.

We heard from RCMP witnesses who were involved in the response on April 18 and 19, 2020, that the shift to a dynamic incident in which the perpetrator was mobile and his movements could not be readily predicted presented great challenges to the entire response. S/Sgt. Bruce Briers explained:

> The problem with this [instance] is that we're – we were behind the eight ball and so you're trying to catch up to what of an individual that knows what they're planning on doing, and we don't have a clue, and there's a lot of areas. So trying to figure out where to best station people in relation to where he was last seen in the Debert area as opposed to – and

> where he's going. Because is he going to Halifax or is he going to somewhere else outside of that area?

Supervisors who were involved in the critical incident response were unanimous in their testimony that the nature of the critical incident response changed significantly between 9:30 am and 10:00 am on April 19, 2020, when reports started to come in via 911 of the perpetrator's actions in Wentworth and Glenholme.

In this phase of the critical incident response, members who had been performing assigned supervisory and investigative roles in the command post and elsewhere shifted their location and role in response to information about the perpetrator's location and activities. In many instances, this shift occurred without the direction or even necessarily the knowledge of the critical incident commander and others whose work was integral to coordinating the overall response. The tasks previously being performed by these personnel largely lapsed. At the time when the RCMP began chasing the perpetrator to Wentworth and Glenholme, there were eight known or suspected murder victims in Portapique, and five more had not yet been discovered by the RCMP.

By 9:40 am, a draft tweet describing the replica RCMP cruiser and including a photograph of the vehicle had been prepared by the Strategic Communications Unit and forwarded to S/Sgt. MacCallum for approval. S/Sgt. MacCallum did not reply, likely because he was responding to the Wentworth homicide dispatch. The request for approval was forwarded to Acting Insp. Halliday at 9:45 am, and approval was granted at 9:49 am. However, the tweet was not posted until 10:17 am.

From 9:45 am, the Enfield and Indian Brook members had taken lookout positions at the border of Colchester and East Hants counties and were monitoring the Colchester radio channel. These members had been assigned positions by Acting Cpl. Stevenson, and she continued to manage the members under her supervision strategically as the mass casualty continued to unfold.

The perpetrator's replica RCMP cruiser was captured on surveillance video driving south on Highway 4 past a residence near Folly Lake between approximately 9:40 am and 9:45 am on April 19, 2020. While the perpetrator was travelling south, Cpl. Rodney Peterson, the Colchester County duty team leader, was travelling north on Highway 4 to respond to the Wentworth scene.

Cpl. Peterson had learned of the events in Portapique from a phone call with a colleague before reporting for duty at the Bible Hill detachment at 9:00 am. When he arrived at the Bible Hill detachment, he met Sgt. O'Brien, who told him they were

looking for a police car and he should put on his hard body armour. Cpl. Peterson was left with the impression the perpetrator could be driving a decommissioned police car. At the time of this conversation, the RCMP had possessed a photograph of the perpetrator's replica RCMP cruiser for more than an hour.

On his way to Portapique, Cpl. Peterson had spoken by phone with Cst. Trent Lafferty and Cst. Adam MacDonald, who were both on his team. Cpl. Peterson learned that multiple people had been shot in Portapique overnight and that they were looking for a police car with decals. He understood this information to mean that the car had once had decals and traces of them could be seen, but not that the car was still fully marked. Shortly after this call, Cpl. Peterson received a Be on the Lookout message on his mobile work station that he believed gave a description and a photo of the perpetrator's vehicle. However, he was unable to open it. Before opening the BOLO, he heard the call concerning Lillian Campbell's homicide in Wentworth. At about 9:47 am, Cpl. Peterson and the perpetrator passed each other just south of the intersection of Highway 4 and Plains Road, while travelling in opposite directions.

Immediately, Cpl. Peterson broadcast his sighting of the perpetrator's replica RCMP cruiser over the Colchester radio channel. He inquired whether they were looking for a "fully marked car" or an "ex-police car." Cpl. Peterson travelled 1.2 kilometres further north before finding a safe spot to turn around, but by then the perpetrator was no longer in view. Cpl. Peterson travelled at high speed south of the Highway 104 overpass but could not locate the replica RCMP cruiser. The perpetrator had driven into Adam and Carole Fishers' property on Highway 4 and eluded detection.

At 9:49 am, the perpetrator turned into the Fishers' driveway in his replica RCMP cruiser. The surveillance video shows him exiting the replica RCMP cruiser, reaching back into the vehicle via the driver's door, and walking toward the residence with what appears to be a rifle in his right hand. The perpetrator was wearing a baseball hat and a high-visibility vest.

The Fishers had seen the RCMP Facebook post identifying the perpetrator, and when they saw him on their property, they retreated from the window, hid separately in the house, and both called 911. Previously, Mr. Fisher had had a few interactions with the perpetrator after the perpetrator asked him to quote on excavation work on one of his properties. The RCMP had not yet released information to the public about the perpetrator's replica RCMP cruiser, but in June 2019, the perpetrator told Mr. Fisher he had just purchased two decommissioned RCMP cruisers

and was "going to put … one back to a marked, fully marked car." Mr. Fisher had called the Bible Hill RCMP detachment with this information at 9:37 am on April 19, after he saw the RCMP Facebook post.

At 9:50 am, following the Fishers' 911 calls, RCMP members en route to the Wentworth homicide call were redirected to Glenholme. Within six minutes, RCMP members, including general duty, Police Dog Service, and Emergency Response Team members, had paused south of the Fishers' residence to regroup and confirm their target destination. They were soon joined by the Emergency Response Team tactical armoured vehicle.

The Department of Natural Resources helicopter was directed to Glenholme and began a perimeter flight around the Fishers' residence.

The RCMP was unaware that it was already too late: the perpetrator had left the area. The perpetrator did not enter the Fisher residence, nor did he hide on their property. Unbeknownst to the Fishers and the RCMP, he had left the property at approximately 9:51 am. The Fishers were unaware that the perpetrator had left and believed he could have been elsewhere on the property. They remained hidden in their home.

After leaving the Fishers' residence, the perpetrator travelled east on Plains Road toward Debert. The replica RCMP cruiser was observed by several civilian witnesses on Plains Road and captured on multiple surveillance cameras, including just before 9:58 am as it passed Dave's Service Centre travelling southeast on Plains Road.

Kristen Beaton, a young wife and mother who was expecting a child at the time, was employed by the Victorian Order of Nurses (VON) as a continuing care assistant. She was known for her kindness with her clients. Ms. Beaton was driving to Masstown and Debert to meet her homecare clients that morning. Her cellphone records indicate she was aware of the incident in Portapique and was actively following the situation, including through social media updates. She texted with her husband on the topic throughout the morning and had two brief calls with him. Sometime before 9:00 am, she posted on a Facebook group called "Local 35 Home Support Workers." The post contained a link to the RCMP Twitter page and the message, "Anyone working in D5 and 7 please be safe and keep your eyes open." At 9:38 am, Nicholas (Nick) Beaton sent his wife a Facebook screenshot of the RCMP warning with a description of the perpetrator, and the two spoke a few minutes later.

Shortly before 10:00 am, Ms. Beaton parked her Honda CR-V in a gravel pullout on the south side of Plains Road, just southeast of the Debert Business Park. This pullout was frequently used by Victorian Order of Nurses staff to do paperwork or make phone calls while making their rounds.

The perpetrator continued travelling on Plains Road to the pullout where Ms. Beaton was parked. He slowed his vehicle, drove into the pullout, and positioned his replica RCMP cruiser next to her vehicle. He fatally shot Ms. Beaton through her driver-side window.

Heather O'Brien was driving a Volkswagen Jetta on the same stretch of road that Sunday morning. She had been employed by the Victorian Order of Nurses for nearly 17 years as a licensed practical nurse. She was also a wife and mother. She was not working that day, but she spoke with her friend and colleague Leona Allen multiple times over the course of the early morning. The two exchanged text messages and phone calls about the active shooter situation. Ms. O'Brien had also been corresponding with her daughters about the events in Portapique and had left her home to bring them coffee.

Ms. O'Brien's Jetta was captured on the Community Metal surveillance camera, heading southeast toward the Plains Road pullout, 30 seconds behind the perpetrator. Ms. O'Brien passed the perpetrator and Ms. Beaton before pulling her Jetta over to the south shoulder of Plains Road approximately 260 metres further on. At that time, Ms. O'Brien was speaking with Ms. Allen by phone. She told Ms. Allen that she saw what she believed to be a police cruiser and heard a gunshot.

The perpetrator drove from the Plains Road pullout and stopped his replica RCMP cruiser next to Ms. O'Brien's car. He got out of his vehicle and fatally shot Ms. O'Brien through her driver-side window. Her vehicle rolled southeast along the shoulder of Plains Road for approximately 60 metres before coming to rest in a wooded ditch on the south side of the road. Ms. Allen heard Ms. O'Brien screaming and the call ended. Ms. Allen immediately tried phoning her back, but her call was unanswered. At 10:02 am, she called 911 to report that her friend, who was in Debert in her car, had said "she heard gun shots, and there was a police vehicle and then all's I could hear was her scream." Other witnesses also called 911 to report the Plains Road fatalities.

After the shootings on Plains Road, the perpetrator proceeded southeast down Plains Road toward exit 13 on Highway 104.

At 10:17 am, more than 12 hours after Jamie Blair's 911 call providing information about the perpetrator's police-decaled cruiser, the RCMP first alerted the public via Twitter that the perpetrator was driving a replica RCMP cruiser. Over the following hour and a half, the RCMP issued eight tweets, posted several Facebook messages, and issued an email media release.

The 10:17 am tweet included a photo of the vehicle with a circle around the fake 28B11 call sign. Posts noting that the perpetrator was in Central Onslow or Debert, driving what appeared to be an RCMP vehicle and wearing what appeared to be an RCMP uniform, were made on Facebook at 10:19 am and Twitter at 10:21 am.

Shortly after 10:00 am, Richard Ellison arrived at the Onslow Belmont Fire Brigade hall comfort centre. Mr. Ellison entered the fire hall at 10:15 am, after speaking with Cst. Dave Gagnon and Mr. Westlake.

Around the time when Cst. Gagnon was speaking with Mr. Ellison and Mr. Westlake, RCMP members Cst. Terry Brown and Cst. Dave Melanson were travelling east on Highway 2 in search of the perpetrator. When Cst. Brown interviewed Lisa Banfield at approximately 7:00 am that morning, he learned that the perpetrator was driving a replica RCMP cruiser that was identical to current RCMP vehicles and that he was last seen wearing an orange vest. Cst. Brown and Cst. Melanson also heard a 10:08 am dispatch about the shootings on Plains Road. They travelled to the Debert area in search of the perpetrator and turned east on Highway 2 toward Onslow.

Shortly after 10:17 am, Cst. Brown and Cst. Melanson approached the Onslow Belmont Fire Brigade hall from the west in an unmarked police vehicle, a Nissan Altima. Cst. Melanson was driving. Both members observed Mr. Westlake wearing an orange reflective vest and standing next to an RCMP cruiser. They did not notice Cst. Gagnon in the driver's seat. Believing Mr. Westlake to be the perpetrator, Cst. Melanson stopped the car in the middle of the road, approximately 88 metres from the monument at the entrance to the fire hall.

Cst. Gagnon was sitting in his marked RCMP cruiser, call number 30B06. Mr. Westlake was standing beside Cst. Gagnon's cruiser. The nose of Cst. Gagnon's vehicle was facing Highway 2, and the rear of the vehicle was close to a stone monument at the fire hall entrance. Cst. Gagnon's vehicle did not have a push bar.

Cst. Gagnon saw Cst. Brown and Cst. Melanson exit their car, raise their weapons, and point them in his direction. Cst. Melanson tried to radio to advise members of what he was seeing, but could not get through. According to Cst. Brown, he yelled for Mr. Westlake to show his hands. Both Cst. Brown and Cst. Melanson reported observing Mr. Westlake duck behind the RCMP vehicle. Cst. Brown fired four rounds from his carbine toward the parked RCMP vehicle, and Cst. Melanson fired one round from his carbine at the same target.

Mr. Westlake heard the words "Get down" before shots were fired, and he started running. He ran into the fire hall and yelled, "Shots fired! Get down! Get down!"

Onslow Belmont Fire Brigade Hall

Onslow Belmont Fire Brigade Fire Chief Greg Muise and Deputy Fire Chief Darrell Currie were inside with the only evacuee in the building, Richard Ellison. The four men took cover at the back corner of the fire hall, behind overturned tables.

Cst. Gagnon stayed in his cruiser while the shots were fired. He used his police radio to identify himself and directed the members to look at the call number on his police cruiser. He called out, "You guys are pointing your guns at me." The Colchester radio transcript also records that he broadcast, "Who are you shooting at? It's Gagnon."

Cst. Brown and Cst. Melanson approached the firehall, spoke with Cst. Gagnon, and performed a brief scan of the area. After they returned to their vehicle, they phoned their superior, S/Sgt. Al Carroll, to report the incident. S/Sgt. Carroll asked a few questions, including whether they were okay, but because the perpetrator was active, he told them to keep going. Cst. Gagnon reported the incident to

Sgt. John Kenny, who was not directly involved in the critical incident response. Sgt. Kenny offered to have someone relieve Cst. Gagnon, but he declined. In his words, "Knowing resources were very limited, I advised I would stay at my post."

Chief Muise and Deputy Chief Currie were not yet aware that the person shooting toward the fire hall was an RCMP member. Deputy Chief Currie continued to monitor the perpetrator's known movements on the RCMP Twitter page. The four men remained hidden for 57 minutes, until they saw a Twitter post stating that the suspect was in Brookfield, which they considered a safe distance from the fire hall.

Sgt. Andy O'Brien and S/Sgt. Carroll travelled to Portapique at about 10:02 am. S/Sgt. Carroll explained that their purpose was to ensure continuity of scene control for future evidentiary purposes. Sgt. O'Brien testified that he did not think to start a canvass for other victims or witnesses. Standard policing procedures involve coordinated door-to-door canvasses to gather eyewitness evidence and to confirm there are no other victims. This task was not assigned to any RCMP member that morning. A member who was assigned to perform "a quick drive through Portapique" to look for anything noteworthy drove along Cobequid Court at around 10:26 am and stopped briefly in front of the Bond residence. However, he did not notice anything amiss. At that time, the Bonds and the Oliver / Tucks had been dead for 12 hours.

Despite a large police presence in the community and phone calls from concerned family members, the RCMP did not conduct a systematic search of Portapique for additional fatalities until sometime after 5:30 pm on April 19.

Through the night and into the morning of April 19, the Operational Communications Centre and RCMP detachments at Bible Hill and Oxford received dozens of calls from concerned family and community members unable to reach loved ones who may have been harmed in the unfolding mass casualty. Other people called hospitals and went to crime scenes seeking information. In most cases, those who placed phone calls were told that information could not be given out. Many callers were asked to provide contact information and told that someone would return their calls. Some of these calls were captured in the incident activity log, but others were not. Information about the Portapique fatalities was circulating through family and community networks, including by social media; for most people, these communications were their main source of information.

Some family members who could not get information by calling the RCMP ended up going to crime scenes to try to learn more. There, some of them encountered

rudeness and threats of violence, including, in some instances, having guns pointed at them. Other members of the affected communities were also unable to get the information they needed when they tried to call their local RCMP detachment or 911. Many of these community members also shared information that was potentially important to the critical incident response, such as when a person was last in communication or that a missing person knew the perpetrator. This information was rarely captured within the incident activity log or communicated by radio. The failure to provide family and community members with a clear way to report concerns and share information also resulted in additional calls coming in via 911, at times competing with more immediately pressing calls about the ongoing incident.

At 10:14 am, Acting Insp. Halliday advised RM Briers that he (RM Briers) would be responsible for allocating general duty members to positions to contain the perpetrator. A few minutes later, CIC West broadcast over Colchester radio that all general duty members were now under the control of the risk manager.

At approximately 10:15 am, S/Sgt. Daniel (Dan) MacGillivray took over the role of critical incident commander from S/Sgt. West, who remained in the command post to assist.

The perpetrator passed through downtown Truro at 10:17 am. This Sunday morning was likely to have been quieter than usual, with fewer people out and about. It was the early days of the COVID-19 pandemic, and most businesses were closed due to health regulations. From Truro, the perpetrator proceeded south on Highway 2 and continued through the Millbrook, Hilden, and Brookfield areas toward Stewiacke and then Shubenacadie. At 10:23 am, his replica RCMP cruiser was caught by video surveillance as it passed the Millbrook RCMP detachment.

Video footage from the Millbrook Mi'kmag'ki Trading Post shows the perpetrator in more detail as he travelled south. He pulled over, exited the replica RCMP cruiser, and removed a navy-blue jacket, which we believe to be a Correctional Service Canada jacket. The jacket was later found in Joey Webber's SUV. The perpetrator appeared to be wearing a grey RCMP shirt and a baseball cap. He removed the high-visibility vest from over the jacket and put it on over the RCMP shirt. He then got back into the vehicle and continued to proceed south on Highway 2 toward the Shubenacadie cloverleaf.

At 10:23 am, RM Briers instructed Sgt. Marc Rose to set up a roadblock on Highway 104 to stop incoming traffic to Truro. At this time, RM Briers began to station as many general duty members as possible on major thoroughfares, including on

Highway 4 near Wentworth, west of Truro near the intersection of Highway 102 and Highway 104, and on Highway 102 around Milford and Shubenacadie.

Between 10:26 am and 10:39 am, the RCMP issued an email media release and posted messages to Facebook and Twitter noting that further updates on the active shooter situation would be provided via Twitter.

At 10:37 am, on instructions from RM Briers, Operational Communications Centre dispatcher Ms. Kirsten Baglee called Truro Police Service dispatch and told them to "lock down" the town. Ms. Baglee then updated Cpl. Edward (Ed) Cormier and Insp. Darrin Smith on the perpetrator's known movements, vehicles, firearms, and casualties and reiterated the request to "shut down" the town. Both of these Truro Police Service officers were unclear about what they were being asked to do.

At 10:39:40 am and 10:40:28 am, while Cpl. Cormier was on the phone with Ms. Baglee, Insp. Smith radioed to all Truro Police Service members to instruct anyone walking outside to go home immediately: "[T]ell them there's an emergency going on, it's not safe to be outside … All units just advise everybody they see to go home. Right now."

At 10:39 am, RM Briers requested over Hants East radio that two carbine-trained Enfield members be sent toward Colchester. Acting Cpl. Stevenson directed Cst. Austin Comeau and Cst. Christopher (Chris) Gibson to go to Colchester County. They were to meet in Brookfield, approximately 22 kilometres north of Shubenacadie. She repositioned other members to account for this change.

At around 10:40 am, radio broadcasts about sightings of the replica RCMP cruiser suggested that the perpetrator might be in Brookfield and travelling south on Highway 2. Acting Cpl. Stevenson realized this information meant that the perpetrator could encounter Cst. Chad Morrison at his position on Highway 2, and she indicated she would move to that position as well.

Cst. Morrison was positioned north of the Shubenacadie cloverleaf and the Shubenacadie River wearing his hard body armour, his carbine ready, and listening to the radio for updates. He noticed a Ford Taurus police vehicle "a couple hundred metres" north of his position, travelling south on Highway 2 toward him.

Acting Cpl. Stevenson was on Highway 215 south of the Shubenacadie River approaching Highway 2 when Cst. Morrison inquired over Hants East radio as to who was approaching in a police cruiser. She replied, "That's me." From this position, she merged onto Highway 2 in Shubenacadie village and soon thereafter entered the Shubenacadie cloverleaf.

Cst. Morrison had begun to put his vehicle in motion to prepare for a quick exit but was put at ease by Acting Cpl. Stevenson's response. Instead, he made "a gentle little U-turn" and pulled his police SUV over on the north side of Highway 224 / Gays River Road. However, the vehicle that Cst. Morrison saw was in fact the perpetrator's replica RCMP cruiser. He did not recognize the perpetrator from the photos that had been distributed until the vehicle pulled up next to him. By then, the perpetrator was pointing a handgun out the driver-side window and began to fire. The perpetrator fired at least three shots, injuring Cst. Morrison. As soon as Cst. Morrison saw the perpetrator, he "hit the gas" and screamed as he drove off.

As Cst. Morrison sought to escape the perpetrator and seek medical assistance, Acting Cpl. Stevenson was accelerating up the eastern ramp of the Shubenacadie

Collision at Cloverleaf

Perpetrator's route travelling south along Hwy. 2 before turning into the opposite lane of the one-way ramp, toward Acting Cpl. Stevenson.

Acting Cpl. Stevenson's route from Shubenacadie onto the eastern ramp of the cloverleaf.

The perpetrator's vehicle (red) was facing southeast, with the rear of his car close to the passenger-side door of Acting Cpl. Stevenson's vehicle.

Following the collision, Acting Cpl. Stevenson's vehicle (blue) was facing north, with the hood against the guardrail.

COMM0007516; labels added by Mass Casualty Commission

cloverleaf. As she was driving up the cloverleaf ramp, the perpetrator, who had continued driving south on Highway 2, crossed the bridge. From this vantage point, he would have been able to see Acting Cpl. Stevenson's vehicle. He turned left onto the eastern ramp, across the oncoming lane, and drove against the flow of traffic toward Acting Cpl. Stevenson's oncoming vehicle. At 10:49 am, he collided head on with Acting Cpl. Stevenson's vehicle near the top of the Shubenacadie cloverleaf ramp.

Acting Cpl. Stevenson exchanged gunfire with the perpetrator before and after she exited her vehicle. During the exchange, the perpetrator fired several shots toward her vehicle. In this exchange, the perpetrator sustained a wound in his forehead from bullet fragments from Acting Cpl. Stevenson's firearm. The perpetrator shot Acting Cpl. Stevenson at close range, killing her before taking her pistol and ammunition.

Earlier that morning, Joey Webber was with his partner, Shanda MacLeod, and their children at their home in Wyses Corner, approximately 25 kilometres south of Shubenacadie. He was a loving partner and father who loved being out in the woods. Ms. MacLeod had been reading about the shootings in Portapique on Facebook and had mentioned them to Mr. Webber. They discussed the location of Portapique as being "out past Truro, Debert area" and agreed that what had happened was "crazy."

Around 10:52 am, Mr. Webber drove into the Shubenacadie cloverleaf and came upon the two crashed police vehicles. He pulled over and exited his car. Witnesses described him as running to help.

The perpetrator either directed or forced Mr. Webber into the back seat of the replica RCMP cruiser, and then shot him. Witnesses observed the perpetrator unloading items from his replica cruiser and placing them in Mr. Webber's SUV. He set the replica RCMP cruiser on fire, and both it and Acting Cpl. Stevenson's RCMP vehicle were eventually consumed by the flames.

Despite being wounded in the exchange of gunfire with Acting Cpl. Stevenson, the perpetrator was able to escape the scene at the Shubenacadie cloverleaf. Around 10:55 am, he drove away in Mr. Webber's SUV, crossed the oncoming lane of traffic, and proceeded south on Highway 224.

Several witnesses contacted 911 and provided contemporaneous observations about what they were seeing at the Shubenacadie cloverleaf.

At around 10:57 am, Emergency Response Team members arrived at the Shubenacadie cloverleaf. They approached with firearms raised, cleared the replica RCMP cruiser, and realized that the perpetrator was not on scene. They did not see Mr. Webber's body in the perpetrator's vehicle, which was fully engulfed in flames. Operational Communications Centre dispatchers had not shared 911 caller reports that a man had been put into the back seat of a police vehicle and shot.

After being shot and radioing for help, Cst. Morrison continued south over the Shubenacadie River bridge, driving ahead of the perpetrator in the southbound lane of Highway 2. He turned right at the cloverleaf onto the western ramp. At the bottom of the ramp, he turned left and drove west and then south on Highway 2 through Shubenacadie and toward Milford.

On the morning of April 19, paramedics Molly McFaul and Daniel Storgato were working at the Milford Emergency Health Services (EHS) base in ambulance M-122. They began their shift at around 7:30 am, and both had little information about the events of the night before. They were advised by dispatch to remain inside the base and avoid any unnecessary travel.

At 10:51 am, an Operational Communications Centre dispatcher called EHS dispatch to report that Cst. Morrison had been shot and was at the Milford base. This message appears to have been misunderstood by EHS dispatch. At 10:55 am, EHS dispatch sent Ms. McFaul and Mr. Storgato a dispatch ticket advising them that an RCMP member required treatment. They were told to remain at the base as the member was en route. They waited in the ambulance bay for the member to arrive.

Cst. Morrison was experiencing a loss of feeling in his hands and was losing grip strength. He realized he would no longer be able to fire his weapon. He went to the back of the EHS building, "wrestled" the magazine out of his carbine, and hid it in the grass. He was experiencing blood loss from a bullet wound in the inner crook of his left arm. Another bullet had entered one side of his right arm, fractured his ulna bone, and exited on the other side. He huddled down in a grassy, marshy area beside the EHS base and waited for someone to find him.

Shortly thereafter, EHS dispatch contacted the paramedics and advised them to look outside for a vehicle. The paramedics located and treated Cst. Morrison and transported him to hospital. Before leaving, they advised EHS dispatch that Cst. Morrison's RCMP vehicle would be left at the EHS base and that there was an empty carbine behind the building.

Sgt. Darren Bernard, commander of the Millbrook detachment, was the first general duty member to arrive at the Shubenacadie cloverleaf scene. He arrived approximately four minutes after the Emergency Response Team members had left. Like other responding members, Sgt. Bernard did not receive an adequate briefing on the morning of April 19. He did not realize that the Emergency Response Team had been on scene. Cst. Comeau, Cst. Jared Daley, and Cst. Gibson were travelling right behind Sgt. Bernard, in separate cars. Within the next few minutes, they too arrived on scene and observed the two police vehicles engulfed in flames. Cst. Comeau pulled up alongside Sgt. Bernard and called out to him that Acting Cpl. Stevenson was on the ground. Sgt. Bernard confirmed that Acting Cpl. Stevenson was dead and stayed with her body while broadcasting details of the scene. Sgt. Bernard looked for Acting Cpl. Stevenson's firearms and radio, and aired his findings over Hants East radio. A delay in patching radio channels interfered with the receipt of this information by other responding members.

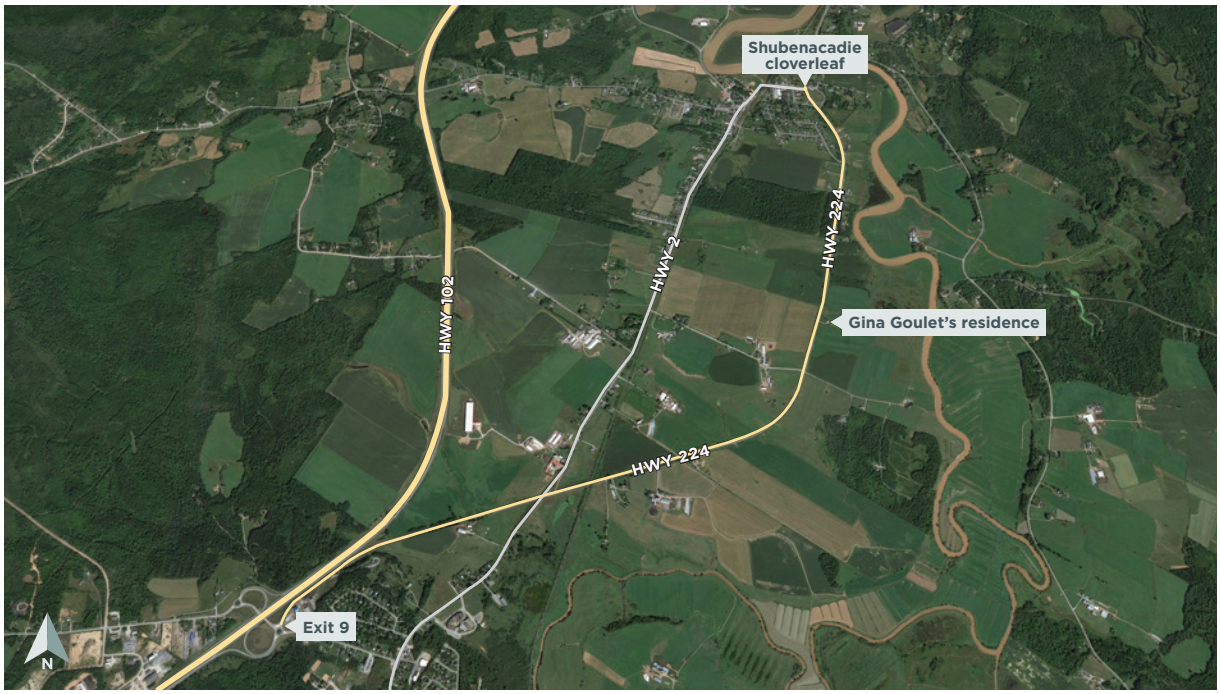
Sgt. Bernard, who is Mi'kmaw, stayed with Acting Cpl. Stevenson. He later explained to the Commission: "[W]e just kind of sat down in the dirt and stayed with Heidi. In my culture, you know, when there's a deceased person, you have to stay with them. So, I kind of stayed with her and just sat in the dirt for I don't know how long."

The perpetrator left the Shubenacadie cloverleaf at approximately 10:55 am, driving south on Highway 224 in Mr. Webber's SUV. He passed Gina Goulet's home on Highway 224, made a U-turn, and drove back to her residence. He parked behind the residence, where the SUV was partly obscured from the road, and broke glass in a side door to enter the residence.

Ms. Goulet was a professional denturist and a cancer survivor. She lived in, and loved, rural Nova Scotia. In 2020, she had been a denturist for 27 years. She had met the perpetrator through the province's relatively small denturist community, including through continuing education activities.

That morning, Ms. Goulet had been communicating with her daughter Amelia Butler by text message. They discussed what they had heard of the incident in Portapique, which by that time was being discussed on various news networks and social media. Ms. Goulet told Ms. Butler that she knew the perpetrator and that another denturist had warned her to keep her doors locked. She said she was scared because the perpetrator knew where she lived. Ms. Butler reassured her mother that "there's no way he could get that far without being caught." She agreed to keep her phone close in case Ms. Goulet called.

Highway 224



Map Data | Google ©2023

At around 10:58 am, Ms. Goulet called Ms. Butler. Ms. Butler explained that her cell-phone rang twice, but as she picked up the phone, the caller hung up. Ms. Butler tried to phone her mother back multiple times but received no answer. Ms. Butler and her husband, David, were increasingly alarmed, so they left their residence and drove toward Ms. Goulet's home.

The perpetrator went into the living area, where he shot one of Ms. Goulet's two dogs. He then went into the master bedroom and fatally shot Ms. Goulet, who was hiding in the ensuite bathroom. He left the residence in Ms. Goulet's grey Mazda 3 hatchback.

By the time the Butlers entered Shubenacadie, a roadblock had been set up by the RCMP to contain the Shubenacadie cloverleaf scene. The detour added approximately 10 to 15 minutes to their drive. They arrived at the Goulet residence at 11:55 am. Ms. Butler called 911 shortly after they arrived. Mr. Butler went inside the house. As he turned toward the hallway, he saw a small silver shell casing and thought he saw blood and what he believed was a body.

While Ms. Butler was on the phone with 911, the Butlers left Ms. Goulet's residence to find help. They headed north on Highway 224 toward the police roadblocks at Shubenacadie. At around 12:00 pm, Mr. Butler flagged down Cst. Comeau, who was on his way back to the Enfield detachment after being relieved at the Shubenacadie cloverleaf scene. The constable had been instructed to leave because he was a colleague and friend of Acting Cpl. Stevenson. Mr. Butler exited his vehicle and told Cst. Comeau what he had seen at Ms. Goulet's residence.

The RCMP Emergency Response Team had left the Shubenacadie cloverleaf at approximately 11:00 am in pursuit of the perpetrator on Highway 224. Either during the period in which the perpetrator was inside Ms. Goulet's home or sometime shortly after he left, ERT members drove southbound past the Goulet residence. RCMP members did not see Mr. Webber's SUV parked behind Ms. Goulet's home.

By this point in the critical incident response, the RCMP had shared information about the perpetrator's disguise and the replica RCMP cruiser with the public. As the morning progressed, more Nova Scotia residents were aware of the mass casualty and that the perpetrator was no longer in Portapique. This knowledge produced an increase in 911 calls, including reported sightings of legitimate RCMP vehicles that members of the public believed might be the replica RCMP cruiser. The Operational Communications Centre dealt efficiently with these calls, for the most part resolving them by checking the caller's location against the mapping of marked RCMP vehicles provided by the Computer Integrated Information and Dispatching System.

As might be expected, some of the information shared by the public proved true, while other information was shown at the time or subsequently to be inaccurate. For example, a community member called 911 reporting a possible sighting of the perpetrator at the Sobeys grocery store in Truro. This information was relayed to the RCMP command post and dispatched to members. Other information – including the timing, the information received from witnesses in the area, and the perpetrator's known direction of travel – contributed to the belief among Emergency Response Team members that the perpetrator was still in the Elmsdale area rather than in Truro. The J Division (New Brunswick) RCMP ERT Team and Truro Police Service officers responded to the Sobeys tip in Truro, while the H Division (Nova Scotia) ERT checked out the Sobeys in Elmsdale, in case there was a mistake about the location. Both teams reported that the areas were clear.

The RCMP H Division Emergency Management Section operates the Divisional Emergency Operations Centre – a coordination centre that is "stood up" or activated

when required in an emergency. It was not activated during the mass casualty. There had, however, been conversations between provincial Emergency Management Office personnel and the RCMP about the availability of the Alert Ready messaging system on the morning of April 19.

At 11:14 am, Mr. Michael Bennett, the Emergency Management Office's incident commander, called Mr. Glenn Mason, the civilian manager of the RCMP Emergency Management Section, to advise that the Emergency Management Office incident command was prepared and ready to use Alert Ready on request by the RCMP. RCMP Operational Communications Centre staff, the command group, and the executive leadership told the Commission that, on April 19, they were not aware that Alert Ready was a mechanism by which information could be shared directly with the public during a critical incident. This lack of knowledge was at least partly due to historical decisions made by the RCMP about Alert Ready.

Mr. Mason called the Operational Communications Centre to inquire whether the RCMP wanted a public alert sent via the Alert Ready system. After a brief telephone exchange, S/Sgt. Steven (Steve) Ettinger told Mr. Mason to go ahead with a public alert. The direction was to use "the bare minimum." Mr. Mason relayed this information to Mr. Bennett at 11:21 am. As we set out in the next section, the perpetrator was killed at 11:26 am. No Alert Ready messages were broadcast in relation to the mass casualty.

At 11:16 am, about four minutes after the false sighting at Sobeys, the perpetrator pulled into the Elmsdale Petro-Canada station and parked Ms. Goulet's grey Mazda 3 at pump 7. He was captured on video surveillance at this location. He briefly reached toward the passenger seat of the Mazda 3 before exiting the vehicle.

Almost simultaneously, Cst. Andrew Ryan, Cst. Jason Barnhill, and Cst. Brent Kelly of the H Division Emergency Response Team parked their vehicle at pump 8 of the same gas station. Canopy pillars stood between the two vehicles. The nose of the ERT vehicle was pointing in the opposite direction of the nose of the Mazda 3. The three constables exited the ERT vehicle just as the perpetrator was picking up the fuel hose at pump 7. All three members were dressed in tactical gear.

After replacing the fuel hose, the perpetrator got back into the Mazda 3. He pulled forward and turned sharply to his right, making a 180-degree turn to pull up to pump 5. There were now two sets of fuel pumps and canopy pillars between the Mazda 3 and the ERT vehicle. After a brief pause at this pump, the perpetrator

drove out of the parking lot without having obtained fuel. His approximate time of departure from the Petro-Canada station was 11:17:05 am, 44 seconds after his arrival. After leaving the gas station, the perpetrator travelled south on Highway 102 to Enfield.

The Perpetrator Is Killed

At 11:24 am on April 19, the perpetrator arrived at the Enfield Big Stop gas station from Highway 2, after turning off Highway 102.

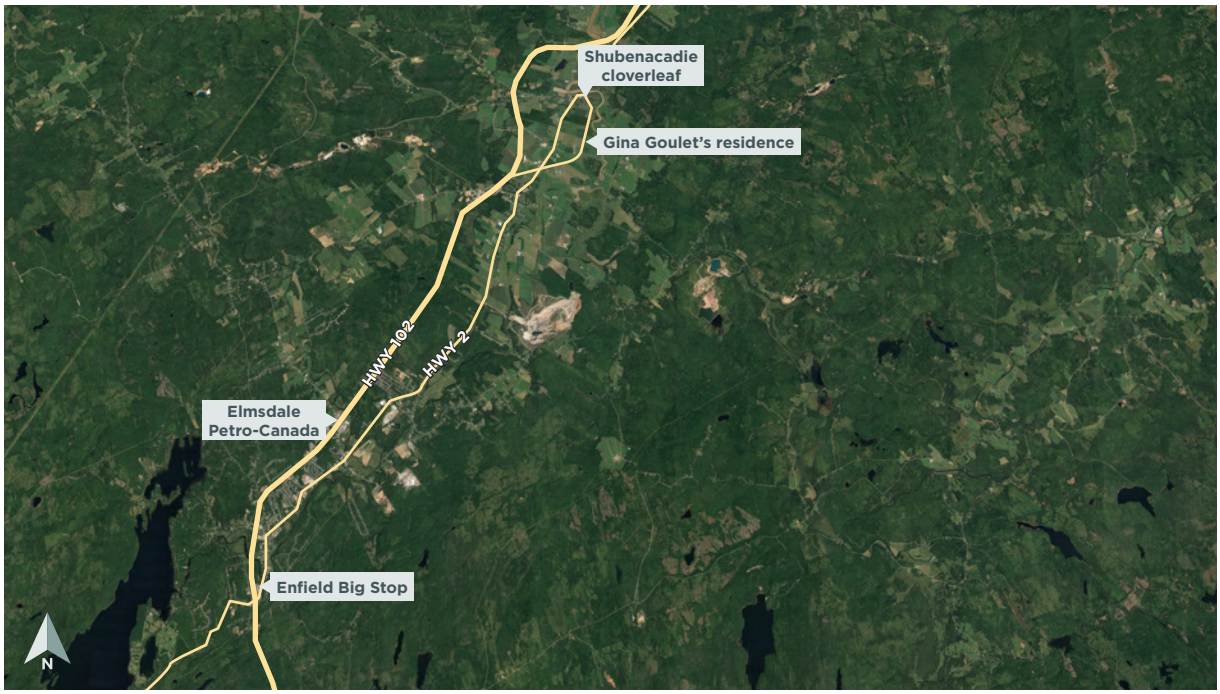
The Enfield Big Stop surveillance videos show that the perpetrator initially pulled in next to pump 7 and then drove around to pump 5 at 11:24 am. He parked the Mazda 3 but remained in the vehicle. Less than 30 seconds later, RCMP Police Dog Service member Cst. Craig Hubley, travelling with Emergency Response Team member Cst. Ben MacLeod, parked his unmarked RCMP SUV at pump 6. The gas pump and a canopy pillar were between them and the Mazda 3.

As he was exiting his vehicle, Cst. Hubley noticed a lone man slouching over in the driver's seat of the grey vehicle on the other side of the pump. He recognized the perpetrator from the photographs he had reviewed that morning and observed his demeanour and head wound. The two were about 15 feet apart. As he drew his pistol and pointed it at the perpetrator, Cst. Hubley shouted "It's him" to Cst. MacLeod.

Cst. Hubley saw the perpetrator react by "jerking back while seated and immediately rais[ing] a silver coloured pistol in my direction with his right hand."

Both Cst. Hubley and Cst. MacLeod testified that they followed their training, shooting multiple rounds in a short period of time to ensure the threat presented by the perpetrator was addressed. After firing these rounds, the two members moved to the passenger side of their vehicle, using the engine block as a barrier in case the perpetrator was still able to shoot them. The surveillance video shows that as Cst. Hubley approached the Mazda 3, the perpetrator changed his position in the vehicle. The Mazda 3 made a rocking motion, and the windows of the vehicle remained intact during this motion. We find in Volume 2, What Happened, that the rocking motion was caused by the perpetrator discharging his firearm, shooting himself in the head just before or at the time when the RCMP members fired on him. The autopsy showed that the immediate cause of death was the

Route to Enfield



Map Data | Google, ©2023 Maxar Technologies

multiple bullets fired by Cst. Hubley and Cst. MacLeod, which caused lethal damage to the perpetrator's internal organs.

Cst. Hubley broadcast the perpetrator's death at 11:27:12 am on the ERT radio channel.

At 11:40 am, the RCMP issued its last tweet of the mass casualty, stating that the perpetrator was "in custody." This information was posted on Facebook at 11:41 am.

The Serious Incident Response Team investigates all serious incidents that arise from the actions of police in Nova Scotia. The team carried out two investigations arising from the RCMP's response on April 18 and 19: one into the perpetrator's death, and the other into the Onslow fire hall shooting.

After the Mass Casualty

In the wake of the mass casualty, the RCMP prioritized institutional and investigative imperatives over the needs of survivors and family members and over public demands for information. This prioritization led to serious shortcomings in the RCMP's information-sharing practices.

Next of kin notifications were not always provided to families in a manner consistent with RCMP policies. Concerns raised by family members include that notifications were not carried out as quickly as possible and that in some cases the notifications were done poorly. During and after the mass casualty, some next of kin notifications were provided on roadsides or near crime scenes, because family members came to the place where their loved ones had died. Other family members experienced a delay before they received a next of kin notification.

Some of these challenges are attributable to the magnitude of the critical incident, but many of the difficulties were systemic rather than situational. There was no coordinated and adequately resourced plan to carry out this important function. In addition, gaps in the RCMP policy and guidelines meant that not all members were adequately trained to carry out these duties with the required sensitivity. The inadequate handling of next of kin notifications caused additional distress to family members. In some instances, it led family members to begin questioning the RCMP's response at this important juncture of transitioning from critical incident to major case investigation.

The RCMP H Division and Nova Scotia Victim Services had responsibility for meeting the information and support needs of survivors and surviving families. They were unprepared for the immense need in the aftermath of the mass casualty for family liaison and a range of support services. Attempts were made to adapt existing services to these needs, but, despite the best efforts of individual service providers, these attempts fell short. Service providers were unable to scale up their services to meet the heightened demand, and the resultant gaps showed a lack of institutional preparation and coordination for an incident of this scale.

The RCMP appointed one person, Cst. Wayne (Skipper) Bent, to act as liaison for all the families of those whose lives were taken, aside from the family of Cst. Stevenson. These families were not well served by the decision to have a single RCMP liaison. While some families expressed appreciation for Cst. Bent's work, he was often overwhelmed by his job. Every aspect of his role was undefined by policy or direction from superiors, including to whom he was responsible to provide

information (for example, which survivors); what information he was supposed to share; and with what frequency. He had received no formal training and, at the time, none existed. Other RCMP officers said they had some experience working with families, but not at this scale.

The families were also disserved by the RCMP's decision to require them to choose only one representative for the RCMP to deal with. This decision placed the responsibility to convey difficult information – and to advocate for more information – on a single family member, thereby placing a great burden on that representative. This approach was untenable when family members did not agree about how best to engage with the RCMP or when there was conflict within families. Both these circumstances were predictable manifestations of the traumatic grief experienced by family members who were bereaved in these circumstances, and not reflective of the families themselves. This approach also did not recognize that families might have different people who might need different information or that an individual family member's capacity to serve as liaison might change over time. In short, it was an approach that was not well suited to the delicate work of supporting families in the wake of a mass casualty.

Lisa Banfield also experienced problems in accessing services. After she was criminally charged, Ms. Banfield and her family stopped receiving information or services from Cst. Bent. She was not provided with another RCMP liaison.

In accordance with the RCMP's *Critically Injured and Fallen Member Guide*, services were provided to the family of Cst. Stevenson by the RCMP, Veteran Services, and Victim Services, and they were assisted by Cst. Randy Slawter and Cpl. Ron Robinson. Cst. Morrison also received information and support consistent with this guide. There is no equivalent policy or definition for family liaisons in the deaths of civilians.

Crime scenes and evidence were not always treated with care. In some instances, evidence was overlooked by RCMP investigators but found by civilians, including family members of those whose lives were taken. In another instance, evidence was returned to family members without being cleaned and without warning that biological matter had not been removed.

The RCMP directed the Nova Scotia Medical Examiner Service not to release information to families of those whose lives were taken, including about the manner of death. This direction was unnecessary in the circumstances of this investigation, and in some instances it exacerbated family members' grief and mistrust. After the

Commission became aware of this directive, we took steps to ensure it was lifted. The Commission connected those families who wished to learn more with the Medical Examiner Service so they could receive information about their loved ones' deaths and have their questions answered privately and directly.

In short, the RCMP did not share all the information it had either publicly or with family members. The reasons for not sharing information were not always clear. Some improvements were made after Jennifer Zahl Bruland, the oldest daughter of John Zahl, advocated that families should receive information from the RCMP directly before it was shared publicly by the media. However, problems continued to arise.

In the days and weeks after April 18 and 19, 2020, the mass casualty was the leading Canadian news story for mainstream media outlets. It also received international media attention. Members of the public looked to the RCMP and to civic leadership for reassurance and for information. They were disappointed by the RCMP's public communications on both counts – starting with the first press conference on April 19, 2020, and continuing until the federal and provincial governments announced a review of (and subsequent inquiry into) the response to the mass casualty.

Some degree of uncertainty was to be expected in the immediate aftermath of the mass casualty, and the media was initially understanding about the challenges facing the RCMP as it commenced its investigative work on multiple complex crime scenes across a wide geographic area. Given the gaps in the information provided by the RCMP, however, journalists soon turned to other sources, particularly community and family members, to understand the chronology of the mass casualty, identify victims, learn more about the perpetrator, and describe the RCMP's critical incident response.

As concerns arose about seemingly changing or incomplete information being provided by the RCMP, media and public scrutiny began to focus on the quality of the RCMP's critical incident response and its public communication practices during and after the mass casualty. Family and community members began publicly expressing frustration at the relative lack of information being shared by the RCMP. For example, Nick Beaton, the spouse of Kristen Beaton, who was expecting a child at the time she was killed by the perpetrator on April 19, 2020, was quoted by the Canadian Press on April 27: "We don't know anything because they're not telling us anything."

By the time of the RCMP's press conference on April 28, 2020, the media was actively investigating several issues potentially arising from the mass casualty, including public communications during the critical incident response and the role of misogyny and violence against women in the mass casualty. Media and the National Firearms Association were also pursuing more information about the types and origins of firearms used by the perpetrator in the mass casualty.

H Division leadership and communications personnel experienced considerable personal and professional strain in the aftermath of the mass casualty. At the same time, the RCMP's most senior leaders, particularly Commr. Brenda Lucki and D/Commr. Brian Brennan, were concerned by what they perceived to be inadequate internal briefing practices and poor public communications.

Inside the RCMP, internal communication challenges persisted between H Division and national headquarters and within national headquarters itself. H Division was providing fewer internal briefings to national headquarters than expected, given the scale of the mass casualty, and H Division appeared slow to provide information requested by national headquarters, including some information that had been requested by Bill Blair, who, as minister of public safety and emergency preparedness at the time, was the responsible minister for the RCMP. A request made by H Division's director of strategic communications for more support went unfulfilled for some weeks as public health measures associated with the COVID-19 pandemic made national headquarters hesitant to send additional communications staff to Nova Scotia.

These dynamics came to a head in the teleconference of April 28, 2020, among nine senior RCMP personnel, five from national headquarters and four from H Division, at which Commr. Lucki expressed her disappointment and frustration about how public communications and internal briefings had been managed in the days since the mass casualty. She explained to the Commission that this meeting reflected "a buildup of frustration" about the problems with public and internal communications. In her words, the purpose of the meeting was to "outline my expectations. I wanted to outline where I felt things weren't going well." During the meeting, Commr. Lucki expressed her disappointment and suggested that the RCMP's inability to promptly deliver information to the responsible minister and the prime minister reflected poorly on the organization. She also emphasized that when the RCMP is not forthcoming with information, the public will look to other sources for answers.

Commr. Lucki specifically addressed the fact that information about the perpetrator's firearms had not been included in the press conference that day. She stated she had received a request from Mr. Blair's office as to whether that information would be forthcoming and had "shared with the Minister that in fact it was going to be included in the news release, and it wasn't." She requested an explanation for why she had been told that information about the perpetrator's firearms would be included in the press conference when that was incorrect. National headquarters staff explained that it had been a misunderstanding on their part. Ms. Lia Scanlan, director of the H Division Strategic Communications Unit, advised Commr. Lucki that, more than two hours before the press conference, she had told D/Commr. Brennan what information the investigative team felt able to share. He had not passed on this information to the commissioner.

In this same context, Commr. Lucki referred to firearms legislation, identifying that legislation then proposed by the federal government "is supposed to actually help police." We conclude in Volume 5, Policing, that Commr. Lucki's audio recorded remarks about the benefits to police of proposed firearms legislation were ill-timed and poorly expressed, but they were not partisan and they do not show that there had been attempted political interference. However, the April 28 meeting both reflected and contributed to the deterioration of the relationship between H Division and RCMP national headquarters after the mass casualty.

The RCMP response to the federal-provincial announcement of an independent review (and subsequent inquiry) was to stop sharing information almost entirely, on the basis that it was inappropriate to do so while a review or an inquiry was ongoing.

We provide a more detailed account of the RCMP's actions after the mass casualty in Part B of Volume 5 of this Report.

Support Services for Survivors and Family Members

The Province of Nova Scotia made funding for individual counselling available to survivors and family members of those whose lives were taken through the Criminal Injuries Counselling Program administered by Nova Scotia Victim Services. The fund normally requires that there be an ongoing criminal case and caps the funding, but in some instances, Victim Services relaxed these rules to help victims of

the mass casualty. Some of those most affected found the process to access this funding smooth, while others found it challenging.

After the mass casualty, Nova Scotia Victim Services established the Stronger Together support navigation program and opened three community support navigation centres – in Portapique, Debert, and Shubenacadie. In early June 2020, a fourth centre was opened in Wentworth. These centres were intended to provide support for families and individuals in the four most affected communities.

Despite this thoughtful initiative, many people reported experiencing difficulties in navigating support systems to access the services they required. Problems included being provided a list of support services that was outdated and included irrelevant services. Most fundamentally, those most affected reported they had to seek out support services. Numerous counsellors on the lists were simply not taking new clients at all, so some family members made many calls before finding someone who would accept them. Many were overwhelmed by having to navigate multiple systems.

Those who were out of province and out of country faced substantial hurdles in accessing funding from Nova Scotia Victim Services. For example, Crystal Mendiuk, who lives in Alberta, described her and her family's experience as a "continual uphill battle." Her entire family had "enormous … difficulties in getting approved for the program."

In September 2022, Mr. Joudrey and his Portapique neighbour Mallory Colpitts attended a consultation with the Commission in which they reflected on their experience of seeking support. Mr. Joudrey observed, and Ms. Colpitts agreed, that while mental health services were made available to them, they found it hard to recover while continuing to live in Portapique. Ms. Colpitts reflected, "[H]ealing or attempting to heal in a place that contributed to a sickness is not easy." Both these residents would have preferred to relocate, even temporarily, for the sake of their mental health, but no financial assistance was available to support them to do so.

Conclusion

On April 18 and 19, 2020, the perpetrator took the lives of 22 people (one of whom was expecting a child at the time), physically injured three others, and inflicted lasting harm on the people, families, and communities who were most affected by his actions. In the early days of the COVID-19 pandemic, Nova Scotians' sense of safety was rocked by the mass casualty. The ripples of this incident extended across Canada and well beyond. In the weeks and months after the April 2020 mass casualty, those most affected, Nova Scotians, and the Canadian public were shaken further by revelations about the RCMP's apparent lack of preparedness for a critical incident response of this scale.

Our mandate directed us to consider the context, causes, and circumstances of the mass casualty. Our work revealed that the antecedents of the mass casualty ran deep into the perpetrator's history of violence and misconduct. This history, in turn, reflects the broader context of our collective social and institutional failures to perceive and respond effectively to gender-based, intimate partner, and family violence. Such failures extend well beyond this perpetrator.

We found that there is a close connection between gender-based, intimate partner, and family violence – in which the perpetrator engaged throughout his adult life – and the rarer phenomenon of mass casualty incidents.

We also looked closely at the aftermath of the April 2020 mass casualty: considering how the most affected families and communities were supported as they navigated their grief and trauma; evaluating the RCMP's work in the days, weeks, and months after the mass casualty; and looking for lessons that we could learn from this mass casualty to help keep Canadian communities safer in the future.

This Final Report documents what we have learned.

Part C:
The Mass Casualty Commission

PART C: THE MASS CASUALTY COMMISSION

The Mass Casualty Commission was an independent public inquiry created to examine the April 2020 mass casualty in Nova Scotia and to provide meaningful recommendations to help keep communities safer.

The Mandate

The Commission's mandate was set out under the authority of the governments of Canada and Nova Scotia in accordance with both federal and provincial public inquiry statutes. The details of the mandate were written in official documents known as Orders in Council. These Orders in Council set the terms of reference as well as the expected outcomes and the time frame within which the work must be accomplished.

Our role as Commissioners was not to determine guilt or assign blame. Our choice was to blame or to learn – and we chose to learn. We were required to establish what happened leading up to, during, and after the mass casualty; to review certain defined issues to understand how and why the mass casualty occurred; and to produce a report that included findings, lessons learned, and recommendations to help keep Canadian communities safer in the future. In addition to inquiring into what happened, we were directed to explore the causes, context, and circumstances that gave rise to the mass casualty; the responses of police, including the Royal Canadian Mounted Police, municipal police forces, the Canada Border Services Agency, the Criminal Intelligence Service Nova Scotia, the Canadian Firearms Program, and the Alert Ready Program; and the steps taken to inform, support, and engage those most affected. We were also directed to examine a number of specific, related issues, including:

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

ii) access to firearms;

iii) interactions with police, including any specific relationship between the perpetrator and the RCMP and between the perpetrator and social services, including mental health services, prior to the event and the outcomes of those interactions;

iv) police actions, including operational tactics, response, decision-making, and supervision;

v) communications with the public during and after the event, including the appropriate use of the public alerting system under the Alert Ready Program;

vi) communications between and within the RCMP, municipal police forces, the Canada Border Services Agency, the Criminal Intelligence Service Nova Scotia, the Canadian Firearms Program, and the Alert Ready Program;

vii) police policies, procedures, and training in respect of gender-based and intimate partner violence;

viii) police policies, procedures, and training in respect of active shooter incidents;

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

x) policies with respect to police response to reports of the possession of prohibited firearms, including communications between law enforcement agencies; and

xi) information and support provided to the families of victims, affected citizens, police personnel, and the community.

These instructions meant that we were to establish a factual foundation through our independent investigation **as well as to undertake significant public policy and research tasks.**

We encourage readers to learn more about the Commission's mandate and Orders in Council in Volume 7, Process.

Mandate

In addition to outlining the mandate for our work, our terms of reference also directed us to:

- adopt any procedures or methods we consider expedient and proper to carry out our work;
- be guided by restorative principles in order to do no further harm, be trauma-informed, and be attentive to the needs of and impacts on those most directly affected and harmed;
- give particular consideration to people or groups who may have been differentially impacted; and
- consider relevant previous reviews and recommendations.

Restorative principles require a non-adversarial, inclusive, and collaborative approach. They oblige us to focus on facts and issues in context rather than in isolation, and on accountability and responsibility rather than on liability or blame. These principles underscore that in seeking answers, we can develop clear understandings, acknowledge harms done, and develop practical reforms. This approach was consistent with other recent commissions and is also consistent with a wide range of initiatives in Nova Scotia that regularly engage restorative principles.

Restorative principles guided the work of the Inquiry to understand how and why the mass casualty happened, but they did not shape or change the Inquiry's

purpose or mandate. Trauma-informed in this case meant understanding the existing trauma and taking it into account as we pursued our mandate; it could not and did not impede our pursuit of the mandate. It *informed* us in order to approach our work in a way that would enable people to participate in the best manner possible to get at the information required. This approach, combined with the nature of a public inquiry as a flexible process, meant that we were able to create processes – and sometimes adjust them as we went on – to try to minimize the ways in which the Commission might cause further harm.

As described in detail in Volume 7, we used several approaches to achieve this goal, always with an unwavering commitment to get the facts, answers, and best information, and ultimately to develop our recommendations. They included paying attention to those identified as differentially impacted by the mass casualty and seeking out and valuing knowledge and input from individuals and groups with different lived experiences. This approach also flowed from the direction to us to attend to past reports and reviews, many of which indicate that actions related to aspects of our mandate, such as policing and gender-based violence, can have disproportionate effects on differentially impacted people and groups. We therefore sought input in framing recommendations to avoid inadvertently deepening structural inequalities.

Our objective was to find out what happened and how and why it happened so that we could distill the lessons learned from the mass casualty and make recommendations to help ensure the safety of our communities in the future. Throughout our mandate, we endeavoured to create conditions that would encourage those who had a direct and substantial interest or relevant information to engage with our work and participate in our efforts to achieve these goals. To that end, we adopted an inclusive, restorative approach rather than a divisive, adversarial one, in the hope that those entrusted with the effectiveness of our institutions and systems will, going forward, continue to operate in this same spirit of individual and collective responsibility.

Achieving the Mandate

To deliver on the Commission's three-part mandate, we developed a series of three overlapping phases that built on each other, starting with establishing a factual foundation of what happened, followed by an exploration of how and why it happened, which all led to developing our findings and recommendations.

Three Phases

In Phase 1, the Commission focused on ascertaining the facts and establishing what happened leading up to, during, and after the mass casualty. Building the core foundation of evidence was necessary not only to answer the public's pressing questions about the mass casualty but also to lay the foundation for completing Phases 2 and 3 of our mandate.

In Phase 2, we examined the causes, context, and circumstances of the mass casualty in order to answer questions about how and why it occurred and to understand the facts in the broader context. In this phase, we focused in particular on exploring issues set out in our Orders in Council, such as best practices for critical incident responses, public communication, supporting individuals and communities after a mass casualty, gender-based and intimate partner violence, and access to firearms.

In Phase 3, we looked forward and focused on what lessons could be learned and how best to make a difference in the future. We consulted with many people, including those most affected, Participants, experts, and members of the public.

Three Pillars

In addition to this phased approach, we organized the Commission's work around three main themes or pillars: Violence, Community, and Policing. This thematic organization helped to connect the dots among specific facts, incidents, issues, contexts, causes, circumstances, and consequences.

OUR MANDATE
Understanding the causes, context, and circumstances of the mass casualty

VIOLENCE	COMMUNITY	POLICE
Issues included: • Gender-based and intimate partner violence • Perpetrator's history of violence	**Issues included:** • Access to firearms • Post-event support • Differentially affected groups	**Issues included:** • Critical incident response • Police communications • Police paraphernalia

In exploring these themes in detail, the Commission's work included the following tasks:

- A review of tens of thousands of documents, videos, and audio files gathered through subpoenas from the RCMP and others.
- A thorough, independent investigation carried out by Commission specialists and counsel involving multiple site visits and interviews with over 230 people, including more than 80 RCMP officers.
- Regular input and submissions from 61 Participants, including those most affected, emergency responders, and groups with relevant subject-matter expertise.
- Sharing 31 Foundational Documents that efficiently organized, analyzed, and distributed the information we gathered through our investigations. Participants were invited to review the Foundational Documents, and their input was incorporated before the documents were shared during public proceedings. The Foundational Documents are supported by more than 6,000 source materials and additional exhibits.

- Hearing from 60 witnesses during public proceedings. These witnesses included more than 30 RCMP members, including the senior officers who were in charge in Nova Scotia and at the national level at the time of the mass casualty.
- Sharing 22 commissioned reports prepared by independent experts which focused on the related issues in our mandate and drew on key government and policy structures as well as on academic research and lessons learned from previous mass casualties. The commissioned reports were supported by more than 1,100 documents of supporting research and policy.
- Environmental scans of past Canadian and international reviews and inquiries that dealt with the matters within our mandate.
- Organizing more than 20 roundtables and other kinds of discussions during public proceedings. During the roundtables, we heard from more than 100 experts and others with relevant experience to share, some of them local and others bringing Canadian and international perspectives.
- Providing information about our work to the public and listening to them to understand the impact of the mass casualty and to assist us in setting our priorities and making recommendations.
- Receiving submissions from more than 900 members of the public, who shared personal experiences of the mass casualty and recommendations for relevant research and suggestions for change.

See Volume 7 of the Final Report for more information about the Commission's approach and process.

Part D:
The Final Report – An Overview

PART D: THE FINAL REPORT – AN OVERVIEW

The Final Report is the culmination of the Commission's independent two-and-a-half-year investigation into the mass casualty, setting out what happened as well as the underlying causes, context, and circumstances.

The Report includes our findings of what happened, helping to answer questions from those involved and from the public. It also includes lessons learned, which capture knowledge gained based on past outcomes and experiences.

The Report includes a set of recommendations that people across our governments, institutions, and communities can begin to take action on right away. Our recommendations cover a wide range of areas, including:

- how to strengthen community safety and well-being, including through focusing more on gender-based, intimate partner, and family violence;
- best practices for critical incident responses;
- how to improve public communication during an emergency;
- how to better support individuals, families, emergency responders, service providers, and communities after a mass casualty;
- how the RCMP can rebuild public trust and deliver effective, rights-regarding policing services in Canadian communities;
- how policing in Nova Scotia may be improved in the near term, and how the Nova Scotian community should be engaged in imagining the future structure of police services in the province;
- how to improve everyday policing practices in Canada; and
- how to more safely manage access to firearms and police paraphernalia.

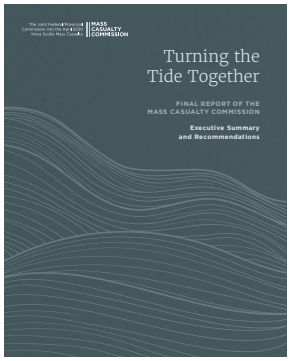
We conclude that preventing mass casualties requires a holistic, public health approach that addresses root causes, including poverty and inequality, and focuses primarily on prevention and early intervention in patterns of behaviour that cause

harm and have the potential to escalate to mass violence. Prevention requires active and concerted "whole of society" response and engagement, all of us working together to address violence in the home and inadequate community support systems. Much of our Report is dedicated to considering what this insight means for the roles and responsibilities of individuals, organizations, and institutions, including police services and particularly the RCMP. Flowing from this, we make recommendations about how this collective response can be fostered through a revitalized public safety system in which police services remain important, but are understood as being only part of a broader community safety ecosystem. The community safety ecosystem is a framework of governmental, institutional, and agency and service provider relationships, including processes for community engagement.

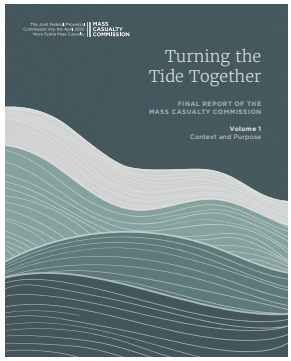
Our main findings, lessons learned, and recommendations are woven throughout the full Final Report and are also available in a complete list in Part E of this Executive Summary.

The Report is divided into volumes, each focused on an area of our mandate. Volumes are divided into parts and chapters focused on specific topics.

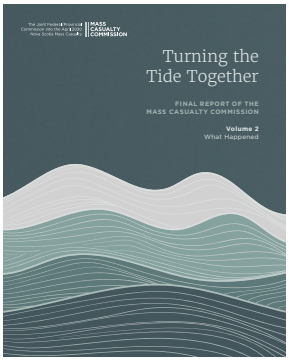
Report Volumes



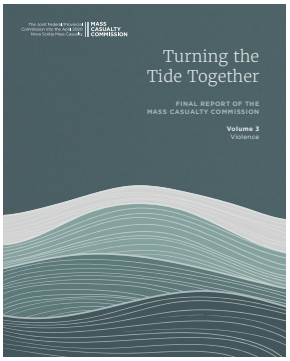
Executive Summary and Recommendations



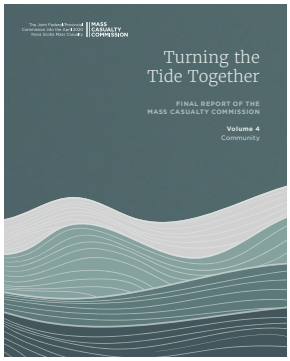
Volume 1
Context and Purpose



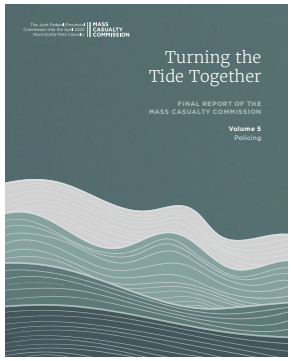
Volume 2
What Happened



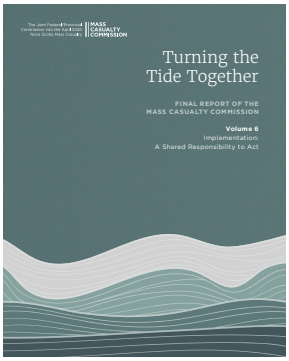
Volume 3
Violence



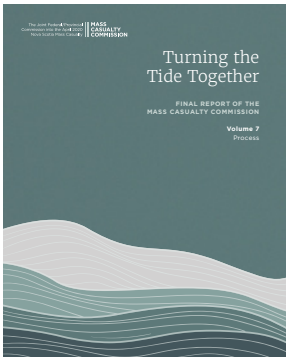
Volume 4
Community



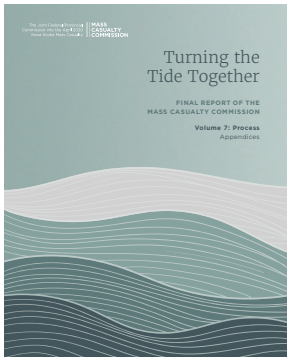
Volume 5
Policing



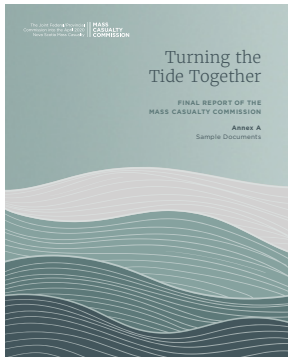
Volume 6
Implementation: A Shared Responsibility to Act



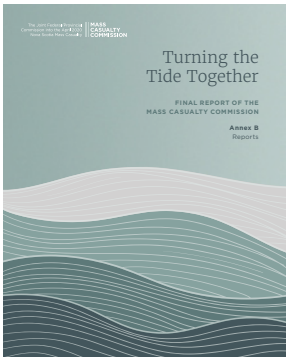
Volume 7
Process



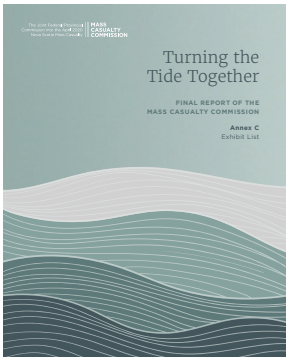
Volume 7: Process
Appendices



Annex A
Sample Documents



Annex B
Reports



Annex C
Exhibit List

Turning the Tide Together: Consolidated Contents

Volume 1: Context and Purpose

Volume 1 begins with acknowledging and commemorating the lives taken in the mass casualty and recognizing the rippling effects of this incident on those individuals, families, and communities most affected. We do so by sharing a selection of first-voice perspectives about immediate and continuing effects. This context – the harms caused by the perpetrator's actions, the significant inadequacies in responses to those actions, and the failures to take preventative measures long before April 2020 – anchored the work of this Inquiry.

In addition to Volume 1 setting out the context and purpose of the Commission's work, it serves as an introduction to the Report. The volume contains four parts, beginning with a commemoration of the lives taken. The second part describes the rippling impact of the mass casualty. It follows the movement outward from the violent centre of lives taken to introduce the individuals and families most affected, and onward to the communities most affected. The third part of Volume 1 outlines the Commission's purpose and approach. This volume concludes with a brief description of the public safety system in Nova Scotia, discussing the public safety organizations that respond to, assess, and take charge when critical incidents happen in our communities. We pay particular attention to some of the agencies that responded to the mass casualty and its aftermath.

The mass casualty of April 18 and 19, 2020, created profound grief, disruption, and destabilization in Nova Scotia and beyond. Early in our mandate, the Commission adopted the image and metaphor of rippling water to signify the breadth and depth of the impact of what happened over approximately a 13-hour period on those two days and in their aftermath. The ripple acknowledges that the immediate impact experienced by those most affected – the individuals, families, first responders, service providers, and local communities – was appropriately the starting point of our mandate. It also captures the dynamic impact of the mass casualty, which expanded outward and affected communities, institutions, and society in Nova Scotia, across Canada, in the United States, and further afield.

We introduced the ripple image as we started our work, and we acknowledge that the rippling effects of the mass casualty will continue after our Report is read and our recommendations are implemented. No one can undo the perpetrator's actions or the actions taken by others in response: these actions are the epicentre of concentric circles of impact caused by one man. Collectively, individuals, communities, the province of Nova Scotia, and all of Canada can learn from this

incident and work together toward enhanced safety and well-being in the future. An appreciation of the depth and breadth of this rippling impact is an essential component of effective, concerted, forward-looking efforts. Just as this impact has focused our work, so too it frames our Final Report.

The Commission learned about the impact of the mass casualty in several ways, including through meetings with family members, witness interviews, individual testimony with supporting documents at public proceedings, two opening panel discussions, small group sessions with directly and indirectly affected individuals, roundtables of people with relevant expertise, and a consultative conference with Indigenous people. In addition, the Commission undertook a number of activities to learn more from community members about this impact, including through community conversations, consultations with stakeholders, and the Share Your Experience survey (conducted to assist us in building our understanding of the experiences of people in a range of different locations, contexts, and settings, including those living in affected communities and those working as emergency responders). We provide an overview of what we learned about the impact of the mass casualty in Volume 1, but it is a central thread woven into the whole Report.

More than a thousand people generously provided their insights into the impact of the mass casualty. This information has created a stronger awareness of the dimensions of the rippling effect: it has expanded our understanding of the range of people who fit into the category of those most affected; and it has enriched our insight into the nature and size of the indirect effects of the circling waves. It has reinforced the perception that, once initiated, a ripple has an immediate effect and that it will not be diminished easily, with its vibrations immeasurably reaching shores in all directions.

As noted above, this volume begins with a commemoration of those whose lives were taken during the April 2020 mass casualty. We asked all the families if they would like to commemorate their loved ones in their own words. In Part A of Volume 1, we set out the memories and the pictures they chose to share with us.

Part B provides an introductory overview of what the Commission has learned about the impact of the mass casualty. It follows the ripple metaphor movement outward from the violent centre of lives taken to introduce the individuals and families most affected (Chapter 1) and onward to the communities most affected (Chapter 2). Chapter 3 sets out a preliminary account of the impact of the mass casualty. We present what we learned from three Commission activities: the opening panel discussion on the human impact; the consultative conference with

Indigenous people; and the Share Your Experience survey. This summary reflects input from those directly and indirectly affected by the mass casualty.

More detailed information about the effects of the mass casualty is contained throughout the Report in specific aspects of the mass casualty response. For example, we consider the ramifications of how public communications, next of kin notifications, and support services provided to family member survivors and other community members were carried out. One focal point of Volume 4, Community, is the nature of the repercussions experienced by emergency responders.

Part C of Volume 1 describes the Commission's work and introduces our Report. In Chapter 4, we introduce our main findings, the nature of the challenges ahead, and the need for concerted, collective action. We introduce a second impact image to our framework to complement the ripple image and mark a shift toward the future: turning the tide together. This tide metaphor also signifies the transition from the Commission to those charged with implementation: governmental institutions and agencies, community-based organizations, communities, and individuals both in their professional roles and as citizens.

In Chapter 5, we describe the Commission's purpose and approach. We set out and explain the purpose of the Commission's work, established by the mandate given to us by the governments of Canada and Nova Scotia, and the processes we developed and carried out independently of governments and other institutions to achieve this purpose.

In Chapter 6, we describe this Report and the approach we took to reviewing, analyzing, and understanding all the evidence and information gathered and developed by the Commission through its three phases of work. First, we set out the analytical framework used to shape this process. Second, we explain the structure of the Report and how it is organized. Third, we provide brief overviews of the content of each of the seven volumes.

Public safety is not just about people being safe but also their feeling safe. It is a perception grounded in freedom from harm and the consequences of crime and disorder in our homes, workplaces, and communities. It comes from the confidence that government and public safety agencies will respond effectively to emergencies, whether caused by acts of nature or human beings.

In Part D, we introduce the public safety organizations that assess and respond when events happen in our communities. These institutions exist to safeguard the

quality of life in our communities. We pay particular attention to some of the agencies that responded to the mass casualty and its aftermath.

We map out everyday public safety, as well as during the response to the mass casualty, for three purposes. First, this part introduces the agencies, their mandates, and the relationships among them to assist the reader in understanding our findings about what happened leading up to, during, and after the April 2020 mass casualty. Second, it lays a foundation for understanding that the way the public safety system functions on a day-to-day basis is one factor that determines our collective ability to respond to critical incidents and other emergencies. Third, in this discussion, we introduce the principle that we have a public safety *system* that is more than its constituent parts.

Volume 2: What Happened

Volume 2 sets out the Commission's main findings in the narrative of what happened leading up to, during, and in the aftermath of the mass casualty of April 18 and 19, 2020. As distressing as it is to recall the violent attack that ended the lives of 22 people (one of whom was expecting a child) and injured others, our mandate requires us to provide a detailed account of these events.

We have striven to include enough detail to give readers a clear, hour-by-hour account of the perpetrator's actions as well as the response of community members and those who had a formal duty to respond. Formal responsibility rests with first and secondary police responders, emergency services personnel (including firefighters and paramedics), and other service providers (for example, tow truck operators and medical examiners). Whenever possible, we include first-voice perspectives from those who experienced the mass casualty as witnesses, community members, service providers, and as responders and overseers of the response. Witnesses and people around the perpetrator have only so much information, however, and analysis of evidence can take us only so far. Some of the perpetrator's actions – in particular, the motivation for his violent rampage – are unknown at this time and likely will remain so forever.

Volume 2 contains the Commission's main findings in two key areas: in narrating how the mass casualty unfolded and in identifying any institutional and systemic

failures discernable in the response, including any missed opportunities to prevent the mass casualty as a whole or in some specific aspects. Identifying what went wrong and what additional steps could have been taken is critical to establishing the lessons that may be learned from the mass casualty. The Commission's work is necessarily both backward-looking and forward-looking.

These findings are a foundation for further and more refined findings in subsequent volumes based on what the Commission has learned about why and how the mass casualty happened. In these subsequent volumes, we elaborate on the lessons to be learned by providing more information about the causes, context, and circumstance of the mass casualty. We draw a direct connection from the findings set out in Volume 2's narrative account to the lessons to be learned and our recommendations. It is our hope that this approach will help to ensure that lessons are in fact learned and integrated into our systems for community safety and well-being, including for those engaged in critical incident response.

Chapter 1 examines the antecedents of the mass casualty – what happened before April 18, 2020. It focuses on information about the perpetrator that contextualizes the mass casualty. The first section presents an overview of the perpetrator's history of violent behaviour, his illegal acquisition of firearms, and his possession of police paraphernalia. The second section sets out what the Commission learned about the perpetrator's behaviour in the weeks leading up to the mass casualty and, in particular, his reaction to the COVID-19 pandemic.

Chapter 2 provides a narrative account of the evening of April 18. The first section contains our findings about the perpetrator's assault on Lisa Banfield and the injuries she suffered. The second section explains what happened in Portapique after this assault. The details are described from three points of view: the perpetrator's actions, resulting in 13 fatalities in Portapique and in injuries to Andrew MacDonald; the observations and actions of other community members, who in many ways were the first responders; and the actions and observations of emergency services personnel who came on scene. The Portapique fatalities were Greg and Jamie Blair; Joy and Peter Bond; Corrie Ellison; Dawn and Frank Gulenchyn; Lisa McCully; Jolene Oliver, Aaron Tuck, and Emily Tuck; and Joanne Thomas and John Zahl. The third section steps away from the immediate situation in Portapique to the RCMP Operational Communications Centre and the non-commissioned officers who worked on the response from further afield. It sets out and examines the RCMP's approach to the critical incident response in the first few hours of the mass casualty. The fourth section reviews the decisions and actions of the RCMP executive

leadership, and the fifth section looks at other agencies involved in the mass casualty and at communications among agencies. The sixth section examines the issue of public communications, including decisions about what information to share with the public, and by what means, during the first two hours. The final section summarizes the Commission's main findings and conclusions about this period.

Chapter 3 provides a narrative account of the period after midnight and into the early morning of April 19. It covers the perpetrator's actions; RCMP decisions and actions; communications between the RCMP and other agencies; actions taken by other agencies; and communications with the public during this period. A final section summarizes the Commission's main findings and conclusions about the events overnight.

Chapter 4 sets out occurrences on the morning of April 19 from 6:30 am to 10:15 am. It begins with Ms. Banfield leaving her hiding place in the woods of Portapique to seek help at about 6:30 am. She had stayed hidden overnight after escaping from the perpetrator's assault. The second section recounts the perpetrator's re-emergence in Wentworth, thereby reactivating an active shooter situation over a larger geographical area than the previous night. This narrative is ordered by the locations where the perpetrator stopped, encountered other individuals, and killed an additional six people: Alanna Jenkins, Sean McLeod, and Tom Bagley on Hunter Road in Wentworth; Lillian Campbell on Highway 4 in Wentworth; and Kristen Beaton and Heather O'Brien on Plains Road in Debert. He also terrorized Adam and Carole Fisher in Glenholme. Again the narrative is told from three points of view: the perpetrator's actions; community members' observations and actions; and actions taken by first-responding police and emergency personnel. Sections that follow continue the examination begun in Chapter 2: the work of the Operational Communications Centre and RCMP command decisions and actions; the role of the RCMP executive leadership; actions taken by other agencies and interagency communication; and the issue of public communications. The final section summarizes our main findings and conclusions.

Chapter 5 examines the shooting at the Onslow Belmont Fire Brigade hall. The first section explains that the fire hall had been set up as a comfort centre for individuals and families evacuated from Portapique. The second section describes an incident at 10:17 am when two RCMP members, Cst. Terry Brown and Cst. Dave Melanson, shot at the emergency management coordinator responsible for the comfort centre, Dave Westlake, and RCMP officer Cst. Dave Gagnon. In the third section, we examine the impact of this incident from three perspectives. First,

we review the actions of Cst. Brown and Cst. Melanson after they drew and discharged their firearms; the actions of their supervisors once they were informed of the shooting; and other steps the RCMP took to address the shooting. Second, we describe the impact this incident had on Mr. Westlake, Cst. Gagnon, and the three individuals inside the fire hall during the shooting: Richard Ellison, father of Corrie Ellison, one of the Portapique fatalities; Greg Muise, fire chief of the Onslow Belmont Fire Brigade; and his deputy fire chief, Darrell Currie. Third, we examine the impact of the fire hall shooting on the Onslow community.

Chapter 6 returns to the account of the perpetrator's actions on the morning of April 19 from 10:15 am until his death at 11:25 am. The first three sections, like those in Chapter 4, are organized around the perpetrator's encounters with individuals at different locations, resulting in three more lives taken and injury to another person: at the Shubenacadie cloverleaf, Highway 224, and before the perpetrator was killed at the Big Stop gas station in Enfield. During the final 70 minutes of his life, the perpetrator shot and injured Cst. Chad Morrison and killed Acting Cpl. Heidi Stevenson, Joey Webber, and Gina Goulet, before being shot and killed by two RCMP members. Each of these location-based sections begins with an overview of the perpetrator's actions, sets out community observations and actions, and ends with the actions of emergency personnel. The remaining sections continue our examination of RCMP command decisions and actions and the role of the Operational Communications Centre, the decisions and actions of the RCMP executive leadership, the decisions and actions taken by other agencies, interagency communications, and the issue of public communications during this period. The final section summarizes our main findings and conclusions.

Chapter 7 provides an overview of the period following the perpetrator's death on April 19, including both the immediate aftermath of this critical incident and the follow-up by the RCMP and other agencies involved in the response to the mass casualty. The first part examines issues around crime scene management, with a focus on the belated discovery of the fatalities at Cobequid Court in Portapique. The second section provides information about forensic investigations and, more specifically, evidence about items in the perpetrator's vehicle at the time of his death and a forensic analysis of the firearms he used during the incident. The third section provides an account of how the RCMP and other agencies addressed the needs of survivors and the families of the deceased for both information and support during this initial period. We also discuss the impact of the RCMP's decision to charge Ms. Banfield with aiding in the supply of ammunition to the perpetrator. The fourth section examines the RCMP's public communications following the

mass casualty. The final section outlines steps taken and the results of internal and external reviews of the response by various agencies to the events on April 18 and 19, 2020. This section includes reviews undertaken by and of the RCMP and by other agencies engaged in the response to the mass casualty. It also provides an overview of investigations carried out by the Nova Scotia Serious Incident Response Team into the Onslow Belmont Fire Brigade hall shooting and the death of the perpetrator.

Volume 3: Violence

Volume 3 builds on the findings we make in Volume 2 about the perpetrator's pattern of violent and intimidating behaviours and illegal acquisition of firearms. Over many years, this pattern gave rise to numerous red flags and missed opportunities for prevention and intervention.

Part A focuses on the perpetrator. The perpetrator was raised in a violent home and became a violent man. The perpetrator witnessed family violence, including intimate partner violence, at a young age. He was abused by his father, who was abused by his own father (the perpetrator's grandfather), who was in turn abused by his father (the perpetrator's great-grandfather).

As an adult, the perpetrator's violent, intimidating, and coercive behaviour extended ever outward: to his intimate partners; to relatives, friends, neighbours, and business associates; to his patients and to vulnerable and marginalized people in the communities where he lived and worked; to individuals in positions of power and control over him such as police officers and colleagues participating in the review of his misconduct at the Denturist Licensing Board of Nova Scotia; and finally to perpetrating a mass casualty. There are strong connections among family violence, gender-based violence, and mass casualties, but it is a complex relationship. Many people are directly and indirectly affected by the violent behaviour of family members; fewer, though a significant portion of them, become violent themselves; relatively few go on to kill. Mass casualty incidents are rare compared to these other kinds of harm, but the perpetrators of these attacks frequently have a history of gender-based, intimate partner, and family violence.

Chapter 1 of Volume 3 begins with an overview of findings about violence within the perpetrator's family. The second section examines his violent and coercive behaviour in intimate partner relationships and toward others: women, denture patients, male acquaintances, friends, and strangers, as well as his threats and threatening behaviour toward police officers. Chapters 2 to 4 scrutinize how the perpetrator acquired the means to carry out the mass casualty: his financial situation and misdealings (Chapter 2), his firearms and ammunition (Chapter 3), and the replica RCMP cruiser and other police paraphernalia (Chapter 4). Chapter 5 provides an overview of what was known about the perpetrator's violent behaviour, firearms, and police paraphernalia, as well as what actions and interventions were taken by individual members of the community, the Denturist Licensing Board, and public authorities. It also includes our findings regarding the perpetrator's relationships with individual police officers.

The experiences other people had with the perpetrator encompassed a range of behaviour, including emotional, psychological, and physical abuse toward intimate partners and coercion and intimidation in those relationships. These accounts echo Ms. Banfield's experiences. The information provided also includes physical and aggressive behaviour associated with alcohol consumption, sexual violence toward low-income women and employees, sexually suggestive comments to patients and employees, and physical violence toward men. Many people were intimidated during encounters they had with the perpetrator.

In Chapter 6 of Volume 3, we examine how and why concerning behaviour – often called red flags or warning signs – was seen, yet interventions were either absent or ineffective. We share what we have learned about the dynamics in these kinds of situations that inhibit affected individuals and other community members from taking action, as well as the patterns in the responses of police and other authorities. The perpetrator's privilege as a wealthy white man contributed to his impunity from adverse official or social consequences for his violence.

Part B of Volume 3 provides an overview of what we have learned about mass casualties. It begins in Chapter 7 by identifying a lack of common definition of these events and the problems caused by this lack of clarity. We then examine trends in the rate and nature of mass casualty incidents. The bottom line is that relatively little is known about mass casualty incidents. This lack of knowledge is partially due to the rarity of these mass attacks. It is also a relatively new area of study, and progress has been hindered by the lack of a shared definition of the term "mass casualty" and limitations on the collection of data. We extended our

knowledge base through an international scan of reports on mass casualties, and Chapter 7 shares some of the comparative insights garnered through our review of reports from the United Kingdom, the United States, Norway, Australia, and New Zealand. In the conclusion to Chapter 7, we set out and discuss our recommendations for a single, inclusive definition of "mass casualty incidents" and also set out factors that should be integrated into data collection and future research and policy development.

In Chapter 8, we turn to the question of whether mass casualties can be predicted. We conclude that a focus on preventing mass violence (by studying patterns of behaviour and addressing root causes of such violence through a public health approach) is more promising than trying to predict it. Risk assessment tools are not useful for predicting rare events such as mass casualties and can perpetuate biases and stereotypes, so utility must be carefully considered. Also in Chapter 8, we examine the use of psychological autopsies by police. These processes are a form of psychological assessment used to evaluate the motivations of the perpetrator of a homicide in circumstances where the perpetrator has died. We consider the scientific value of these tools, the concerns and best practices related to them, and evaluate the RCMP's psychological autopsy of the perpetrator against these standards.

Chapter 9 examines psychological and sociological insights into the perpetrators of mass casualties. We identify violence as a gendered phenomenon, interrogate the relationship between traditional masculinity and mass violence, and review the clear connections between gender-based violence and mass casualties. Studies show that mass casualties are committed almost universally by men. The consistency in this gender variable across time and place warrants close scrutiny. We review findings from recent sociological studies that explore three interrelated dimensions of this gendered phenomenon: the connections between mass casualties and gender-based violence; traditional masculinity and masculinity challenges; and the role of gun culture.

We find in Part B that the strong connection between gender-based violence and mass casualties continues to be overlooked in much research and commentary, as well as in measures to prevent and respond to violence, including mass casualty incidents. Gender-based, intimate partner, and family violence is dismissed as "private" violence, but this violence harms us all. As Dr. JaneMaree Maher, professor in the School of Sociology at Monash University in Melbourne, Australia, explained in her testimony:

> It impacts those around – both the victim and the perpetrator. It impacts children. It impacts family members. It impacts health services. It impacts workplaces. So there is always a sense in which private violence is always already having public effects that we are increasingly aware of.

Seeing "private" and "public" violence as two distinct phenomena is incorrect and dangerous.

All too often, gender-based, intimate partner, and family violence are precursors to the forms of violence that are more readily seen as being of broader "public" concern. We ignore these forms of violence at our collective peril.

While no person or institution could have predicted the perpetrator's specific actions on April 18 and 19, 2020, his pattern and escalation of violence could have and should have been addressed. Many red flags about his violent and illegal behaviour were known by a broad range of people and had been brought to the attention of police and others over a number of years. It was entirely predictable that he would continue to harm people until effective intervention interrupted his patterns of behaviour.

Mass casualties occur infrequently, but women, children, and other marginalized people and communities experience violence every day. Our perceptions of where the real danger lies are misconceived, and we ignore the hard truth of the "everydayness" – the commonness and seeming normalcy – of violence between intimate partners and within families and the ways in which this violence spills out to affect other people too. Gender-based violence is also ubiquitous and under-reported in Canada. For far too long, we have misperceived mass violence as our greatest threat without considering its relationship to other more pervasive forms of violence. We do so at the expense of public safety and community well-being.

The evidence shows clearly that those who perpetrate mass casualties often have an unaddressed history of family violence, intimate partner violence, or gender-based violence. Many mass casualties begin, as this one did, with an act of family violence. The societal and cultural misapprehension that these forms of violence are distinct from one another is mirrored in most institutional practices and priorities, notably in policing, the media, and the delivery of public services. We conclude that strategies to prevent mass casualties must focus on ensuring the safety and well-being of all community members.

In Part C of Volume 3, we build a framework for preventing mass casualties with a focus on insights derived from seeing mass casualties as an escalation of gender-based violence, including intimate partner violence, and from acknowledging their connection to family violence. The pattern of escalation from gender-based violence to mass casualties is well established. It is alarming to know that some people responded to the early RCMP communications on the night of April 18, 2020, by thinking, "It's a domestic situation." The mistaken implication is that a "domestic situation" is not one that sets off warning bells. And yet it should, not because every incident of gender-based or family violence will result in mass casualties, but because the first step in prevention is in recognizing the danger of escalation inherent in all forms of violence. As Commissioners, we believe this lesson to be the single most important one to be learned from this mass casualty. Let us not look away again.

In drawing the overarching lessons to be learned, we delineate our collective failures to protect women from gender-based violence in Chapter 10. In searching to explain these failures, we look at the state of our knowledge about risk factors, barriers to reporting, the ineffectiveness of many current interventions, and our growing knowledge about coercive control. Our conclusion is that failures to protect women, girls, and Two-Spirit, lesbian, gay, bisexual, transgender, queer, intersex, and additional sexually and gender diverse (2SLGBTQI+) people from gender-based violence cannot be attributed to a lack of knowledge.

Women and Survivors:
Paying Attention to the Complexity and Diversity of Experience

Throughout this Final Report, we mainly use the words "women" and "women and girls" to refer to survivors of gender-based violence. Violence is a gendered phenomenon in that it is mainly perpetrated by men and it has a disproportionate impact on women. We therefore refrain from using the gender-neutral term of "survivors" (or "victims") except where quoting another source or where required for clarity.

We also focus on violence against women, and particularly intimate partner violence, because of its close connection to the mass casualty. We acknowledge, however, that our efforts must be to eradicate all forms of gender-based violence and its impact on all survivors.

In this Report, the term "women" has an additional burden of being a single word that incorporates and stands in for the more nuanced and complex diversity of women in Canada.

We use the term "women" as inclusive of 2SLGBTQI+ people who identify as women and acknowledge that they, too, are disproportionately subjected to gender-based violence.

Statistics confirm that the impact of gender-based violence is even more severe on some communities, particularly those who are marginalized within Canadian society: Indigenous women and girls; Black and other racialized women; immigrant and refugee women; 2SLGBTQI+ people; people with disabilities; and women living in northern, rural, and remote communities. We discuss some of the root causes of this disproportionate impact in our Report.

We encourage readers to be mindful of the complexity and diversity of women's experiences of gender-based violence wherever we refer to "women" and "women and girls."

Gender-based violence is an epidemic in Nova Scotia and in all of Canada, as it is in most parts of the world. The United Nations has been calling it a global pandemic for years. Violence against women and girls is also endemic in Canada and "in all societies." Calling gender-based violence endemic accentuates the ways in which it has been consistently present throughout societies to the point that it is seen by many as routine or normal.

Within this context, we revisit Lisa Banfield's experience and look at the ways she was revictimized in the aftermath of the mass casualty as an example of some of the ways in which we fail to adequately address gender-based violence. We conclude Chapter 10 with a brief summary of evidence of the impact of our collective and systemic failures. An active and concerted whole of society response is required to counter this scourge.

In Chapter 11, we look at the state of our knowledge about the ways in which we have failed to prevent gender-based violence, thereby keeping women and girls unsafe. We focus on understanding five areas where we collectively continue to founder: limited understanding of risk factors and inappropriate and uneven use of risk assessments; overcoming barriers to reporting; reliance on ineffective interventions; misconceptions and minimization of coercive control; and underfunding

and defunding of effective interventions. Our conclusion is that failures to protect women from gender-based violence cannot be attributed to a lack of knowledge. We recognize the efforts of many individuals and organizations over decades – and that some progress has been made in some areas. Yet gender-based, intimate partner, and family violence continue to prevail with sweeping and wide-ranging consequences. We conclude that this prevalence is the result of inadequate and uncoordinated action by individuals and organizations, coupled with insufficient attention to structural and institutional barriers that block progress.

In Chapter 12, we conclude Volume 3 by recognizing that our Report comes at a critical juncture for Nova Scotia and all of Canada, given the governmental commitments in the Nova Scotia Standing Together to Prevent Domestic Violence initiative and the National Action Plan to End Gender-Based Violence. These initiatives build on the many previous reports and, in particular, the ongoing work to implement the recommendations made by the National Inquiry into Missing and Murdered Indigenous Women and Girls. Our Report joins in this collective call to action and underscores the ways in which the April 2020 mass casualty provides further reasons for us all to take on this individual and shared responsibility.

Throughout Volume 3 we offer recommendations, based on our Inquiry, for a path forward toward preventing mass casualties through a fundamental reorientation of our collective responses to gender-based, intimate partner, and family violence. In Chapter 12, we set out four lessons learned through our work that can help us to achieve that fundamental reorientation: mobilizing a whole of society response; situating women's experience at the centre; putting safety first; and taking accountability seriously. Putting safety first necessitates lifting women and girls out of poverty, decentring the criminal justice system, emphasizing primary prevention, and supporting healthy masculinity.

Our mandate is to inquire into the April 2020 mass casualty and the related causes, context, and circumstances that surround it. The focus on one mass casualty incident is notable in light of both historical patterns of violence and the ongoing reality of violence in the lives of many members of our communities, both rural and urban. The disproportionate impact of this ongoing violence on Indigenous people and members of the African Nova Scotian communities has been further compounded by law enforcement (both over- and underpolicing these communities) and by a lack of culturally responsive and effective public services. Throughout our work, as we learned how the perpetrator targeted members of marginalized

communities in Nova Scotia, we realized it provided but one example of the ways in which historical patterns of violence are sustained and amplified.

We recognize this reality while at the same time we acknowledge both the limitations and the gravity of the Commission's mandate. It is our sincere hope that lessons learned and solutions recommended may assist in addressing other manifestations of violence within Canadian society. We have attempted to pay attention to this wider frame of reference in our work and, in particular, by being mindful of the potential for unintended negative consequences of our recommendations for members of marginalized communities. Our mandate requires us to be concerned with the safety of all communities – and with all members of these communities. We can meet this requirement only by paying close attention to the needs of the most marginalized and by working with them to develop inclusive safety plans, supports, and strategies to meet the needs of everyone concerned.

Volume 4: Community

In Volume 4, we focus on the role of communities and their members in responding to critical incidents and in contributing to community safety and well-being. Communities and their members are affected by critical incident responses and by systems for ensuring everyday safety. They also have an active role in responding to incidents and in contributing to community safety and well-being on an ongoing basis. The structure of our Report recognizes that we need to rebalance the relationship between communities and police in ensuring public safety. To put it simply, communities come first.

Our consideration of the theme of community begins with a recognition of the rural dimensions of the April 2020 mass casualty. The mass casualty took place across Colchester, Cumberland, and Hants counties, a relatively large geographic area of central Nova Scotia comprising rural areas and small towns. Portapique and Wentworth are small, isolated communities, for example, and the population density is fewer than 15 people per square kilometre. This mass casualty is the largest such incident to occur in a series of rural communities, and this rural character is a contextual factor that helped to shape the incident itself and the response both during and after April 18 and 19. Rurality also contextualizes our understanding of

developments before the mass casualty. The perpetrator moved between his cottage in Portapique and his residence in Dartmouth, earning his income in denturist clinics in Dartmouth and Halifax (with a significant rural client base) but spending the greater part of each week in Portapique.

Part A of Volume 4 explores the ways that life in rural communities is different from other environments. Although each rural community is unique, there are some common features about rural ways of living that coalesce into the idea of "rurality." In Chapter 1, we examine the concept of rurality and rural life in Nova Scotia and, generally, in Canada. We also address firearms ownership and use in rural communities. Chapter 2 provides an overview of research and statistics about rural crime. It also considers two current and related policing challenges: lack of community trust and confidence, and recent developments in self-defence in the rural context. In Chapter 3, we review Commission evidence about rural community well-being, with a focus on Nova Scotia. As we move forward from the mass casualty, it is essential that space is made for rural communities and rural voices in conversations and decisions on how best to ensure community safety and well-being.

Part B of Volume 4 introduces and explores the concept of community-centred critical incident responses. Community members play a part in everyday safety, and communities and their members are active agents in all phases of critical incident response. A central lesson learned is that developing a community-centred approach to critical incident response should be the focus moving forward. This change requires putting communities at the centre and encompasses community-engaged processes at all stages: prevention and mitigation, preparedness, response, and recovery. To fulfill these roles effectively, communities should be involved in planning and preparations, and community members will require education and training before a critical incident. To protect lives and promote safety, communities and their members will require warnings and other information during an incident. Communities and their members also require information, supports, and resources after an incident to assist them on their path to restoring health and well-being, including the re-establishment of a sense of safety. Supporting communities and their members to full recovery assists in the prevention of and mitigation of long-term negative outcomes that could contribute to future critical incidents.

In Chapter 4, we consolidate what we have learned about post-incident support into a framework for community-centred responses to mass casualty incidents. The first section of the chapter establishes the parameters for understanding

impact by exploring who is affected by a mass casualty and what the impact is on health. The second section examines three approaches to understanding post-incident needs and concludes with a brief discussion of the impact of unmet needs. The third section proposes a set of principles to guide community-centred critical incident responses, and the fourth identifies several promising practices. The conclusion draws together these elements into a framework of guiding principles.

In Chapter 5, we examine the development and implementation of effective public warning systems. We focus on evaluating whether Alert Ready can provide the robust public warning capabilities needed to ensure a community-centred response to mass casualty incidents and other threats to public safety. We begin by explaining key concepts and terms and providing a historical overview of emergency alerting and the development and operation of the Alert Ready system. We also explore alternative approaches to public warning systems. We build on this foundation by setting out what we have learned about community needs and experiences during the April 2020 mass casualty, and more generally about the differential impact of alerting. On the basis of this foundation of background information and community perspectives, we assess Alert Ready and develop a set of public alerting system design principles to guide reform. A concluding section contains our recommendations in this area.

Chapter 5 focuses specifically on our findings with respect to the need for a more effective public warning system going forward. Deciding on the best system for public warning is a decision for the Canadian public – a decision for communities. The use of these systems by police agencies is a separate though equally important issue, to which we turn in Volume 5, Policing.

In the ensuing chapters of Part B, we explain that public systems must be prepared to respond to mass casualty incidents by having information and support systems in place to meet the needs of individuals, families, and communities affected by the incident. Communities and their members also require information, supports, and resources after an incident to assist them on their path to restoring health and well-being, including the re-establishment of a sense of safety. Supporting communities and their members to full recovery assists in the prevention of ongoing (and mitigation of long-term) negative outcomes that could contribute to future critical incidents. We assess approaches taken to meet the support needs of all those affected by the April 2020 mass casualty.

In Chapter 6, we probe how community-centred critical incident responses can meet the information needs of affected persons during and after a mass casualty.

We build on our findings about the information needs of those most affected by the April 2020 mass casualty and take a broader look at the victim services approach employed by the RCMP. We examine proposals to revitalize this approach and then consider more transformative avenues tailored to the scale of these incidents. We describe some promising practices in this regard. We conclude by setting out the lessons learned, as informed by the framework of guiding principles established in Chapter 4, and make a recommendation designed to ensure the capacity to meet the needs of survivors and affected persons following a mass casualty.

In Chapter 7, we use a similar structure to examine how best to meet the support needs of emergency responders. We use the term "emergency responders" to mean all individuals who respond to an emergency, including fire, police, and paramedics, as well as others, who by virtue of their occupation or volunteer role, are involved in responding to a critical incident either immediately or in the hours, days, and weeks after a critical incident. The list includes everyone from the communications operator who takes a 911 call to emergency room nurses, to those who volunteer in recovery efforts, and those who process and restore crime scenes, including professional cleaners and tow truck operators. Another term for this group is "public safety personnel," but emergency responders is more reflective of their role as it connects to our mandate. As we noted in Volume 1, Purpose and Context, we estimate that 500 to 600 people were involved in their work capacity in the response to the April 2020 mass casualty and its aftermath.

Chapter 7 is divided into three parts. The first part examines approaches to understanding the needs of emergency responders following a mass casualty incident. This examination considers impact and steps that can be taken to facilitate healthy help-seeking behaviours. The second part explores prevention and proactive planning for wellness. We conclude this second part with our main findings, lessons learned, and a recommendation focusing on ensuring planning and preparedness for community-centred approaches to critical incident responses that integrate a wellness-focused preventative approach. The third part reviews the steps taken to meet the needs of emergency responders following the April 2020 mass casualty. We then take an in-depth look at the experiences and perspectives of emergency responders in accessing support services to meet these needs. The concluding part draws together these experiences with a focus on proposals made by emergency responders about what steps could be taken to improve the support provided to this group in the future.

In Chapter 8, we examine how best to meet the support needs of affected persons and communities. The support needs of affected persons and communities can be met both through the formal channels established by public sector institutions, such as healthcare delivery systems, and more informally through community-based and individual, personal channels. We focus here on formal mechanisms for providing support through healthcare systems and victim services. This chapter begins with an examination of approaches to understanding the support needs of affected persons and communities following mass casualty incidents. It summarizes the information explored in Chapter 1 and builds through discussions about categories of needs, types of support services, and community needs. The second section sets out in detail the approaches taken by Nova Scotia Health Authority and Nova Scotia Victim Services, a program of the Department of Justice, to developing and implementing support systems and services following the April 2020 mass casualty. The third section details the experiences and perspectives with these services. The final section contains our conclusions, main findings, lessons learned, and recommendations.

In Chapter 9, we consider community-based responses to the April 2020 mass casualty. We heard from many community members of Colchester, Cumberland, and Hants counties that they do not want to be defined by the April 2020 mass casualty, and we heard about the steps they were taking to move forward and foster resilience. At the same time, there is extensive concern about the breadth and depth of unmet need for support within the most affected communities. We conclude there has been a "healing deficit" that amounts to a public health emergency, and we make recommendations for urgent action to promote recovery and support resilience.

In Part C of Volume 4, we consider how to establish safety ecosystems that actively engage community members in the promotion of safety and well-being of every individual and the community as a whole. In Chapter 10, we outline the Canadian experience with community policing and examine obstacles to implementing new models of policing that result in unfulfilled promise. We conclude that rather than starting with questions about the role of policing, we need to recalibrate the question and start with community. We pose two questions: What makes communities safe? What makes rural communities safe? Our response is that system-wide planning for community safety and well-being holds the greatest potential to achieve these objectives.

In Chapter 11, we recommend that federal, provincial, and territorial governments enact frameworks for community safety and well-being and resource them through long-term sustainable funding. These frameworks provide the structure, but it is community engagement that will be their animating force. It is community members and their organizations across Canada who will determine what is required to meet their needs for community safety and well-being. The focus should be on creating the right conditions for change, not on coming up with the right program or strategy.

In the first section of Chapter 11, we set out what we have learned about the steps required to create the conditions and structure for substantive community engagement: committing to equality, establishing planning frameworks, and leading guided processes for the generation of a shared vision of community safety and well-being. In the second section, we identify mechanisms to build the infrastructure required to facilitate the implementation of plans for community safety and well-being, including through continued community engagement. These mechanisms are ongoing collaboration, multi-sectoral approaches, and evaluation.

What will change in our society if we begin from the starting point that we are all responsible for keeping each other safe? In Chapter 12, we examine what this collective responsibility approach means for some of the actors and entities that do not have a formal role within the safety ecosystem: individuals, businesses, and the media. One of our focal points here is developing a stronger culture of bystander intervention. We also consider the role and responsibilities of professionals who deliver public services to individuals who are marginalized by their low-income status and through other oppressive processes including systemic racism. This focus flows from our earlier findings about the perpetrator's pattern of predatory, violent, and intimidating behaviour toward members of the African Nova Scotian community in Dartmouth and the North End of Halifax (in Volume 3, Violence, Part A). Our analysis extends more generally to government oversight of public service provision by independent professionals to members of marginalized communities. We pay particular attention to reassessing these roles and responsibilities as they relate to the April 2020 mass casualty. This reassessment also serves as an example of the type of recalibration that will enable an effective whole of society response.

Our mandate directs us to inquire into the perpetrator's access to firearms and police paraphernalia as aspects of the causes, context, and circumstances of the April 2020 mass casualty. In Part D of Volume 4, we examine what steps should

be taken to apply the lessons learned through the Commission's work to the systems we have in place to regulate and enforce access to firearms and police paraphernalia.

One of our core findings is that the enforcement of Canada's firearms regime was inadequate to prevent the perpetrator from acquiring the means to carry out the April 2020 mass casualty. In Chapter 13, we evaluate this regime on the basis of how it operates in conjunction with other aspects of our public and community safety systems. It is Canadian society, our community of communities, that decides on which lethal weapons should be available for civilian use, for which purposes, and under which conditions.

In the first section, we provide a snapshot of the firearms situation in Canada designed to provide background information and context for the discussions that follow. It consists of an overview of the regulation of firearms and a range of statistical data about guns and their use. The second section is a summary of our findings on the perpetrator's access to and use of firearms and an identification of the issues that arise from these findings.

The third section sets out what we have learned about mass casualties, firearms, and firearms control. We explore the relationship between guns, gun control, and mass shootings in the United States and briefly review American responses to these events. We analyze the firearms-related responses to mass casualties in New Zealand, the United Kingdom, and Australia and draw lessons to be learned from these international experiences. The fourth section surveys Canadian firearms regulation, beginning with a historical perspective and moving to developments after the April 2020 mass casualty. Here we focus on the way technological developments, mass casualties, and other crimes have shaped Canada's approach to gun control.

In the fifth section of Chapter 13, we move to a forward-looking perspective on violence prevention through gun control. The discussion is structured around three main strategies: legislative and regulatory reform, addressing cross-border smuggling of firearms, and strengthening regulatory enforcement. The sixth section examines the other side of the prevention equation, looking beyond regulation to issues such as public awareness and education and the mechanisms to promote community safety. The chapter ends with our conclusions and recommendations.

"Police paraphernalia" is the term adopted by the Commission for police vehicles, uniforms, and equipment, whether or not genuine. Police equipment includes

varied items: firearms and other less lethal weapons; equipment associated with police vehicles such as "silent patrol" partitions and light bars; and police identification badges. It also includes highly sensitive and secure items such as encrypted police radios, police-issued laptops, and police notebooks.

In Chapter 14, we examine the effects of police impersonation on public trust. We heard very clearly in our community consultations and public proceedings that the police impersonation aspect of the April 2020 mass casualty had a ripple effect on public trust in the police, and particularly the RCMP. We review the broader policy issues involved in the regulation of police paraphernalia, including systems to manage the inventory and disposal of these items, and the challenges involved in regulating access to many specific items of police paraphernalia. We conclude that measures to address these issues must be systemic and comprehensive.

In Chapter 15, we explore approaches to cultivating healthier masculinities. This discussion builds on our findings and recommendation in Volume 3 with respect to the role of unhealthy conceptions of masculinity in the perpetration of violence. We conclude that initiatives in support of cultivating healthy masculinities will contribute to one of the main cultural shifts required to end gender-based violence, and, moreover, that they are an important strand in a whole of society response.

In the first section, we summarize information gathered by the Commission about a public health approach to preventing male violence. In the second section, we explore initiatives to cultivate healthy masculinities in relation to four main preventive public health strategies identified in Volume 3: prevention, early intervention, response, and recovery and healing. Chapter 15 is a case study of one set of initiatives that communities should consider for inclusion in their safety and wellness plans.

Volume 5: Policing

In Volume 5, we build on the findings and conclusions reached elsewhere in this Report by turning to the institutional context of policing. This volume contains four parts. In Part A, we evaluate the quality of the RCMP's critical incident response on April 18 and 19, 2020. Part B documents the continuing crisis that afflicted the RCMP in the days, weeks, and months after the mass casualty. In Part C, we build a

framework for improving community safety by making police agencies more democratically accountable, more attentive to evidence about good practice, and better oriented to articulating and serving the common good rather than particular interests. Part D of Volume 5 considers the everyday practices of policing that contribute to the overall effectiveness and legitimacy of the police.

Complex critical incidents are characterized by uncertainty and by their singularity. The individuals who were professionally involved in the critical incident response were placed in that position because they were assigned to work in H Division on the day when the perpetrator set out to murder and cause mayhem. In these circumstances, mistakes and misjudgments on the part of responders and supervisors may be inevitable**.** We recognize that these individuals did their best in unprecedented circumstances and that, ultimately, it is the perpetrator who is responsible for his actions. Nonetheless, in order to evaluate the quality of the critical incident response, it is necessary to look carefully at the decisions and actions taken and not taken by some individuals, particularly those who occupied supervisory and leadership roles.

Our evaluation, first, of the decisions made at key points in the critical incident response and, second, of the RCMP's overall preparedness and processes for critical incident response, is offered in the service of learning the lessons that may be drawn from the mass casualty in order to help keep communities safer in the future. At every step where it was possible for us to do so, we have chosen to learn and not to blame. Our mandate directs us to choose learning, and in Part A of Volume 5, with that objective, we share details about the critical incident response that offer lessons for future preparation and response.

In Chapter 1, we set out five principles of effective critical incident response that emerge clearly from the extensive research and policy literature we reviewed. These principles are the importance of critical incident preparedness in the quality of a critical incident response; the uniqueness of every critical incident and the conditions of uncertainty under which decision-makers must act; the necessity of cultivating a culture of interoperability, in which organizations and personnel consistently work respectfully and collaboratively; the importance of recognizing the role played by community members during a critical incident and of communicating effectively with community members; and the value of grasping the opportunity to learn from a critical incident response in order to respond more effectively in the future. These principles guide our discussion of the critical incident response on April 18 and 19, 2020, and of the RCMP's institutional

preparedness for effective critical incident response. Also in Chapter 1, we introduce the 2014 report prepared by Ret'd. A/Commr. Alphonse MacNeil after a mass casualty incident in Moncton, New Brunswick, in which three RCMP members were killed and two more were injured. We explain the significance of the MacNeil Report to our work and also identify some limitations to that report.

In Chapter 2, we evaluate the RCMP's policies and preparedness for a large-scale critical incident response in rural Nova Scotia in April 2020. In particular, we consider the extent to which the RCMP had absorbed and implemented the lessons learned and recommendations from the 2014 Moncton mass casualty incident and from the MacNeil Report. We find that some good work was done in the immediate aftermath of the Moncton incident, but that work was not institutionally sustained and did not produce lasting improvements in preparedness and supervisor training.

Chapter 2 also addresses the quality of the RCMP's critical incident decision-making during the April 2020 critical incident response. We analyze the origins and effect of particular problems identified in the main findings in Volume 2, What Happened: uncertainties about command structure; a lack of training for front-line supervisors; the time taken for a trained critical incident commander to take command; the failure to make contingency plans for alternative scenarios; and shortcomings within the command decision-making at various phases of the critical incident response. Throughout this chapter, we document the impact on the overall effectiveness of the RCMP's critical incident response of prioritizing reactive pursuit of the perpetrator over seeking to coordinate the response to ensure that other important tasks, such as seeking out and attending to other possible victims and witnesses, were also completed.

Chapter 3 evaluates the RCMP's processes for finding and managing information and explains how the clear and consistent account of the perpetrator's replica RCMP cruiser that was provided by community members was lost to the critical incident response. In particular, we identify shortcomings in the RCMP's training, processes, and procedures for managing information during a critical incident response. We share the evidence we heard about best practices for emergency communications centres and information management during a critical incident response, and make recommendations for future practice. Also in Chapter 3, we discuss four additional areas that presented particular challenges to the critical incident response of April 2020: tracking RCMP member locations; the RCMP's use of mapping technologies; police radio protocols; and the availability of air support.

The RCMP was not the only organization that played a role in the critical incident response of April 18 and 19, 2020. Other police and emergency service agencies were also directly involved in the critical incident response. In Chapter 3 of Volume 5, we share what we learned about how best to cultivate the culture of trust and mutual understanding that is essential to interoperability. We make recommendations to ensure that future critical incident responses are better coordinated across all responding agencies.

The evidence we received in our process demonstrates that lives can turn on ensuring accurate and timely public communications during a mass casualty. Accordingly, in Chapter 4, we evaluate the institutional processes and decision-making that led to the RCMP's failure to issue effective public warnings in April 2020. We emphasize that the RCMP was aware of the importance of public communications in critical incident response well before April 2020. The RCMP's failure to have adequate processes and training in place in H Division in April 2020 must be understood against this backdrop. In particular, we consider the history of institutional decision-making that led to a situation in which the command group was unaware of the potential to use Alert Ready to broadcast a public warning about a mass casualty. This chapter also identifies and challenges the persistent operation of myths about how community members will respond to public warnings. We emphasize the police responsibility to issue public communications about how an incident may affect people and the steps they can take to keep themselves safe. It is unreasonable to expect community members to figure these things out for themselves.

Part B of Volume 5 documents the continuing crisis that afflicted the RCMP in the days, weeks, and months after the mass casualty. In Chapter 5, we consider the efforts made – and those not pursued – to learn from the critical incident response. More than two years after the event, RCMP leadership had done very little to systematically evaluate its critical incident response to the deadliest mass shooting in Canada's history. We discuss the significance of the RCMP's failure to conduct an operational debriefing with those who responded to the April 2020 mass casualty, and evaluate the evidence we heard about the fate of efforts made by some RCMP personnel to obtain an after-action review of the critical incident response. Returning to the five principles of effective critical incident response, we emphasize that the lessons learned from a critical incident response are not specific to the responding agencies or to where the incident took place. The public is owed not only the exercise of a review but the sharing of lessons learned with the broader community to help keep us all safer. Waiting months or years to conduct

an after-action review serves no one. Indeed, had the RCMP conducted and published a comprehensive after-action review, some of this Commission's findings and recommendations would likely have been addressed by the organization well before the publication of this Final Report.

In Chapter 6, we turn to the RCMP's public communications and internal relations after the mass casualty. We set out the policies and procedures that relate to public communications and identify a history of reviews and inquiries making adverse findings about and recommendations for change to the RCMP's approach to public communications. We document evidence that the RCMP provided inaccurate information to the public after the April 2020 mass casualty. We then discuss concerns that arose inside and outside the RCMP about its public communications, as well as concerns within the RCMP about internal briefing practices and a lack of support provided to H Division to assist with public and internal communications after the mass casualty. These concerns set the context for an April 28, 2020, meeting between Commr. Brenda Lucki, members of national headquarters, and senior members of H Division. We describe the circumstances that led to this meeting and evaluate what happened during the meeting. In the final sections of this chapter, we discuss the continuing ramifications of the April 28 meeting for the relationship between H Division and national headquarters, and the persistence of internal conflict within the RCMP over public communications in the months after the mass casualty.

In Chapter 7, we turn to issues management and inter-agency conflict after the mass casualty. This chapter explains the genesis and role of the issues management team established in H Division, including a disagreement with the Province of Nova Scotia about how this team should be funded. We evaluate the RCMP's approach to two issues that attracted great public interest in the months after the mass casualty: the risks and benefits of using the Alert Ready system for policing, and the 2011 Criminal Intelligence Service of Nova Scotia bulletin about the perpetrator. In particular, we consider inter-agency conflict that arose between H Division and municipal police leaders in Nova Scotia about how these issues should be publicly addressed.

In Chapter 8, we turn to the work performed by the Nova Scotia Serious Incident Response Team (SiRT) after the mass casualty and the work performed by the RCMP with respect to the SiRT's investigations. The SiRT investigated two incidents involving RCMP members arising from the April 2020 critical incident response: the Onslow fire hall shooting, and the killing of the perpetrator. In July

2020, the RCMP referred evidence it had received about another Nova Scotia police service to the SiRT, and the SiRT declined to investigate this information. We explain the SiRT's jurisdiction in relation to the RCMP and describe its public reporting responsibilities. We explain communications between the SiRT and the RCMP. We then turn to the RCMP's July 2020 referral and the SiRT's handling of this referral.

Public trust in the police is integral to the police's capacity to do their work effectively. Public trust is, in turn, affected by public conversations about how well the police do their work, and by how police agencies respond to those public conversations. The April 2020 mass casualty, and more particularly the RCMP's response to public concern about its response to the mass casualty, created significant public mistrust in the RCMP. However, for many community members, particularly those who have a history of being overpoliced and underprotected by police, trust in the police was already low. Conversations about the RCMP's work in the April 2020 critical incident response played out against a broader conversation about the role and limits of the police in fostering and safeguarding community safety. In Parts C and D of Volume 5, we turn to the role of the police within an inclusive vision of community safety.

In Part C, we address fundamental questions about the role and structure of police agencies in Canada. In Chapter 9, we consider the question, What are the police for? We suggest that establishing clear answers is a precondition to democratic deliberation about the functions the police serve and how they do their work. We adopt, and recommend that Canadian police agencies and governments adopt, eight principles of policing that address the role of police in a democratic and inclusive society. Chapter 9 also explains how the lessons learned (and not learned) by police and government agencies from past reports about policing, and the efforts made (and not made) to implement and sustain this learning, have shaped our work and recommendations.

In Chapter 10, we propose a future for the RCMP. First, we take stock of what we learned about the current state of the RCMP's management culture and operational effectiveness, particularly in its contract policing service. We recommend statutory amendments to the *RCMP Act* to clarify the relationship between the RCMP commissioner and the responsible minister, and also to strengthen the role of the RCMP Management Advisory Board and the Civilian Review and Complaints Commission. In each case, these amendments will also promote the public transparency and democratic accountability of these bodies. We then turn to the

RCMP's relations with its contract partners. A recurring theme of reviews of the RCMP is the challenge of ensuring that the RCMP's provision of contract policing services is responsive and accountable to the communities it serves. We conclude that the RCMP's tendency not to include contracting partners in its strategic decision-making, documented in past reports, persists, and that the RCMP has failed to adopt a strategic or coordinated approach to contract policing policies and core policing functions.

We then turn to the important topic of rural policing. The RCMP's career model undervalues rural general duty policing, regarding that work as the first step in a career ladder that will bring members to other policing functions and locations. This approach creates a disconnect between RCMP members and the communities they serve, and it fails to recognize and foster the distinctive skillset that is required for effective rural policing. We identify that maintaining the unique responsibilities of police under the rule of law necessitates that adequate policing services be provided in rural and remote communities.

Throughout this Final Report, we emphasize that effective police agencies are learning institutions: capable of recognizing and responding to the changing expectations of the communities of which they are part, and capable of learning from their past actions in order to do better in the future. In the next section of Chapter 10, we explain how police recruitment, education, and research contribute to the effectiveness of police services, and we evaluate the RCMP's approach to these functions.

The last section of Chapter 10 discusses the RCMP's management culture. By management, we refer to commissioned officers, which in the RCMP means those sworn members who hold the rank of inspector, superintendent, chief superintendent, assistant commissioner, deputy commissioner, and commissioner. We also include civilian employees who hold equivalent ranks or leadership positions. We are particularly focused on management culture because, if the RCMP is to make the significant changes we call for in this Report, the work of leading these changes and engaging members in them will be led by commissioned officers and their civilian equivalents. Indeed, if the RCMP's management does not share a commitment to making these changes – or worse, if some members of management actively work to undermine efforts to reform the RCMP – these efforts will likely fail.

In Chapter 11, we turn to the future of policing in Nova Scotia. We provide a brief history of policing in Nova Scotia and a description of the present structure of policing services in the province. This chapter also describes some of the key

reforms that have been made to the police in Nova Scotia since colonization. We then set out six recommendations for changes that should promptly be made to Nova Scotia policing. These changes can and should be implemented while broader conversations about community safety are unfolding. We call for a structured community-wide process to discuss and decide the future structure of policing services in Nova Scotia.

Part D of Volume 5 considers the everyday practices of policing that contribute to the overall effectiveness and legitimacy of the police. In Chapter 12, we explain that low-visibility decision-making is a defining feature of police work and a particular characteristic of the work performed by front-line police officers. The discretion exercised daily by police officers in their interactions with community members is best understood as a permission that is extended by society to individual police officers to use "their considered judgment in certain ways in certain situations." Legal and constitutional principles, including *Charter* rights and freedoms, set limits to police discretion. Nonetheless, most exercises of police discretion will never come to any form of official attention or review. At the same time, these decisions have a significant impact on what crime and social problems come to broader official attention and how effectively social problems are countered. They also affect community trust in the police.

The police power to shape the official record by the manner in which front-line officers exercise discretion is not merely a theoretical concern. In our process, we heard about police failures to hear and respond effectively to community members who expressed fear of the perpetrator or sought to report his violence. These accounts were echoed in other incidents that were well known to, and widely discussed among, community members and experts who contributed to our work. Two other examples from rural Nova Scotia arose repeatedly in these conversations: the RCMP response to complaints made in 2017 by Colchester County resident Susan (Susie) Butlin about her neighbour Ernie Duggan before Mr. Duggan killed Ms. Butlin; and the RCMP's treatment in 2007–8 of Digby County resident Nicole Doucet (also known as Nicole Ryan), who was subjected to violence including coercive control by her husband, Michael Ryan. We introduce these examples in Chapter 12 and return to them throughout Part D of this volume, along with other evidence we heard about how police exercise their discretion when gender-based and intimate partner violence are reported.

The problems that we document throughout this Report are long-standing and far from simple. However, in Chapter 13, we suggest that everyday policing practices

can be improved by implementing a coordinated set of fundamental strategies, each of which is designed to improve how front-line police exercise their decision-making authority in low-visibility situations. These five strategies address the selection of police students and police recruits, police education, note taking and record keeping, front-line supervision and feedback, and community-engaged policing.

Chapter 14 of this volume builds on recommendations made in Volumes 3, Violence, and 4, Community, to consider the relationship between everyday practices of policing, equality, and securing community safety. We identify the need to shift police officers' understanding of their role to acknowledge the primacy of securing the safety of those who experience violence. We also identify the central role played by misogyny within the police failings that are documented throughout this Report. These problems are not limited to the RCMP: they are also present in other Canadian police services. Indeed, as we documented in Volumes 3 and 4, misogyny is not by any means limited to policing. Nonetheless, the operation of misogyny within policing is particularly harmful to women's equality, and therefore to all of us, and can undermine achievements in law reform and efforts to modernize policy. In Chapter 14, we suggest that countering misogyny, racism, homophobia, and other attitudes that undermine universal human dignity must be placed at the centre of everyday policing practices across Canada.

Volume 6: Implementation – A Shared Responsibility to Act

Our mandate required us to conclude our work as Commissioners by submitting findings, lessons learned, and recommendations. Rather than the end of a process, however, we encourage you to think of this Report as a beginning or, even better, as a continuation of the effort many people have already made to strengthen community safety and well-being, including by advocating collectively for the Inquiry. Recommendations alone cannot bring about change unless they are adopted, championed, and acted on.

Implementation has been an important consideration for us throughout our work. We have made it a priority to hear perspectives and insights related to implementation from many people – including many of those who lead or who are part of institutions and groups that will need to drive important changes. Volume 6 draws on what we learned about implementation and is motivated by the urgent need to ensure that action is taken and that positive changes in our communities can – and will – happen.

Chapter 1 explores the interconnected nature of the recommendations in the Report and makes the case for why they must be implemented on a comprehensive basis and with a whole of society approach. In this chapter, we explain the purposive architecture of our recommendations built of three components. Two components, foundational ideas and a scaffolding that will guide the construction of a new approach to community safety, together illustrate the unity of purpose and strategic directions that underlie the many proposals for cohesive community-engaged safety ecosystems. Recommendations directed to effective critical incident response are a third component – the storm wall that will protect the structure in difficult times.

Chapter 2 acknowledges that the path to change has many potential barriers and sets out strategies to overcome these obstacles. These strategies draw on what we have heard and learned from many practitioners and experts over the course of our work, as well as on what we have learned through the environmental scan of prior recommendations and the international scan compiled by the Commission (available in Annex B: Reports). We hope that these general lessons learned about how to effectively implement reports of public inquiries, task forces, and reviews will provide guidance and assistance with implementing this Report.

In Chapter 3, we share our recommendation for a broadly representative Implementation and Mutual Accountability Body that should be appointed by the federal and Nova Scotian governments to ensure that the recommendations drive ongoing focus and action. In keeping with our architectural metaphor, this body is the keystone: the last building piece, the one on which other structural elements can depend for support. A keystone is considered essential to maintaining optimum function of a structure.

Finally, in Chapter 4, we share steps and actions that those most affected, community members, community organizations, advocacy groups, policy specialists, researchers, the media, and the public can take to maintain the momentum behind implementation. We believe these steps and actions will grow in depth and impact

when people come together with intent to make change happen. The examples we provide are not exhaustive, and individuals and groups will have their own ideas about how to make changes that are best for their communities.

Volume 7: Process

Volume 7 describes the various processes involved in leading and designing the Mass Casualty Commission. This volume provides a comprehensive record of the steps we took and the reasons behind them. Understanding how we carried out our mandate provides a backdrop to the findings, lessons learned, and recommendations detailed in the other volumes. Our added purpose in setting out those steps and decisions in detail here is to provide assistance to future inquiries.

There are seven chapters in this volume. Chapters 1 and 2 provide general information about the nature and role of public inquiries. As Commissioners, we were bound to the directions provided to us in the Orders in Council by both Canada and Nova Scotia (Appendix A). Those Orders required us to conduct a comprehensive public inquiry to determine what happened and to make recommendations to avoid such incidents in the future. They required us to consider a wide range of causes, context, and circumstances beyond the immediate ones that were most directly of interest to the families of those whose lives were taken. Although we grounded our work each and every day in the memory of those whose lives were taken and diligently sought to answer the questions the families had about their loved ones, we were required to conduct a public inquiry as directed by the Orders in Council.

Chapter 2, "Establishing the Mass Casualty Commission," explains the genesis of the Commission and the mandate it received from the governments of Canada and Nova Scotia that defined its parameters. Both the public pressure that led to the Commission's establishment and its mandate "to be guided by restorative principles in order to do no further harm" are important contextual factors underlying our work. These principles were to guide the process but did not limit or shape its purpose (in getting to the truth of what happened) nor its goal (to make recommendations for the future). While restorative principles guided our work, they were not an end in themselves.

In Chapter 3, "Designing the Inquiry," we discuss the logistics of getting the Commission off the ground. We share how we benefited from early consultation with individuals who have expertise working on public inquiries, along with where we chose to establish our offices and our approach to hiring staff. We also introduce the individuals and groups who engaged in the Commission's process as Participants, and we explain what that role entails. We then provide information about rules we developed in consultation with Participants to guide our process, and how we supported participation and public engagement throughout our mandate. We explain how we implemented communications through dedicated efforts to engage the public, including how we worked with the media, in that public engagement. We also consider the impact of the COVID-19 pandemic on the Inquiry and offer some thoughts on the Interim Report.

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

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

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

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

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

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

The conclusion is followed by our acknowledgements of those who contributed to this work.

Volume 7: Process Appendices and Annexes

The appendices include, among other documents, our Rules of Practice and Procedure, our decisions, and a detailed calendar of our public proceedings. We have also prepared three additional annexes. "Annex A: Sample Documents" contains samples and guiding documents we prepared in the course of our work. These annexed documents provide further insight into our processes that we hope will assist future inquiries. "Annex B: Reports" contains reports commissioned by us as well as reports prepared by our team. In addition to providing a wealth of knowledge and analysis within our commissioned reports, this Annex includes important documents such as the environmental scan of 71 past Canadian reports and a record of what we learned through the Share Your Experience survey and community conversations. "Annex C: Exhibit List" contains the full list of materials marked as exhibits by the Commission.

Part E:
Main Findings, Lessons Learned, and Recommendations

Part E: Main Findings, Lessons Learned, and Recommendations

We frame our conclusions in three steps. First, we identify findings that pertain to the questions and issues laid out in our mandate. From these main findings we identify lessons learned, which reflect the knowledge we have gained. From these lessons learned, we build our recommendations so that people across our governments, institutions, and communities can begin to take action right away.

Our findings, lessons learned, and recommendations are woven throughout the Report and we encourage you to review them in that context too. They are also included here as a complete list to aid understanding and implementation.

Volume 2: What Happened

Chapter 1 Events Before April 18, 2020

MAIN FINDING Over many years, the perpetrator's pattern of violent and intimidating behaviours and illegal acquisition of firearms gave rise to numerous red flags and missed opportunities for prevention and intervention.

MAIN FINDING In the six weeks before the mass casualty, the perpetrator further isolated his common law spouse from her family as his behaviour became erratic and increasingly concerning to her.

Chapter 2 Events on April 18, 2020 – Portapique

MAIN FINDING The mass casualty began with the perpetrator's violent assault of his common law spouse, Lisa Banfield.

MAIN FINDING Community members were an essential part of the initial response to the mass casualty. Their central role was not adequately acknowledged, and the indispensable information they could provide was not factored into the RCMP's response.

MAIN FINDING First-responding members acted appropriately when they established an Immediate Action Rapid Deployment (IARD) response and entered Portapique and when they established an initial containment point at the intersection of Portapique Beach Road and Highway 2. These members acted with great courage in an extremely dangerous environment.

MAIN FINDING The RCMP's failure to assign a scene commander created gaps in the initial critical incident response. These gaps meant that aspects of the response were not well coordinated and that important tasks, such as identifying eyewitnesses and flagging the need to conduct interviews, were not prioritized and therefore not conducted in a timely manner, and in some cases not at all.

MAIN FINDING Key information conveyed by 911 callers from Portapique was not accurately or fully captured within the RCMP incident activity logs, nor was it fully conveyed to first responders and the RCMP command group.

MAIN FINDING The critical incident package call-out process was cumbersome, requiring many individual phone calls to supervisors and specialist resources.

MAIN FINDING RCMP policy did not clearly assign supervisory roles and responsibilities for the period before a critical incident commander assumes command of the critical incident response. Uncertainty about these roles and responsibilities was evident from an early stage within the RCMP's response in Portapique.

MAIN FINDING When it became apparent that Sgt. Andrew (Andy) O'Brien could not attend the scene to assume the role of scene commander, the district command group should have appointed an alternative scene commander.

MAIN FINDING The RCMP command group wrongly concluded that Portapique community members were mistaken when they reported seeing the perpetrator driving a fully marked RCMP cruiser. They were too quick to embrace an explanation that discounted the clear and consistent information that several eyewitnesses had provided independently of one another.

MAIN FINDING RCMP supervisors did not direct basic investigative steps during the initial critical incident response in Portapique, nor did they assign responding members to capture information that would facilitate investigation. Important community sources of information were ignored, with significant consequences for the critical incident response.

MAIN FINDING RCMP members did not have a good understanding of the geography of Portapique, and many had never been there before April 18, 2020. The RCMP did not seek out local knowledge about back roads, and information that was shared by a member who was on scene was overlooked.

MAIN FINDING District command efforts to review containment were hampered by computer difficulties in the Bible Hill detachment. Not all RCMP supervisors were trained in the mapping technology to which the RCMP subscribes.

MAIN FINDING During the initial critical incident response, and in the absence of a scene commander or an on-duty district supervisor, RM Rehill was overtasked.

MAIN FINDING The RCMP did not make effective systematic efforts to alert Portapique residents to the threat presented by the perpetrator or to look for potential injured victims. The initial Immediate Action Rapid Deployment (IARD) responders

focused on finding the perpetrator, and this focus was appropriate for that group. However, the overall command decision-making did not adequately consider how best to protect and, if necessary, to rescue Portapique residents.

MAIN FINDING The RCMP's lack of preparation and contingency planning for air support to be provided during a critical incident when maintenance is being conducted created a distraction for Operational Communications Centre (OCC) employees and command. The search for an alternative helicopter diverted these personnel from other important tasks.

MAIN FINDING The RCMP public communications during the evening of April 18, 2020, seriously understated the threat presented by the perpetrator and the associated risks to the public.

Chapter 3 Events Overnight

MAIN FINDING There was an unacceptable delay in the assumption of command by a fully trained and briefed critical incident commander.

MAIN FINDING The RCMP critical incident command structure lacked a dedicated information analyst.

MAIN FINDING The RCMP critical incident command did not adequately consider a wide range of scenarios, including worst-case scenarios, and failed to develop contingency plans based on the most severe possible outcomes.

MAIN FINDING The RCMP's failure to act on the clear and repeated information about the perpetrator's replica RCMP cruiser continued overnight on April 19, 2020.

MAIN FINDING The RCMP critical incident command failed to review containment when they had the opportunity to do so. This failure meant that gaps in the containment, which had arisen in the absence of a scene commander, were not addressed.

MAIN FINDING The RCMP critical incident command did not develop and operationalize a general evacuation plan, nor did it take into account possible survivors of the violence.

MAIN FINDING The RCMP critical incident response was hindered by system-wide poor communication and failures of coordination.

MAIN FINDING The RCMP did not provide further public communications about the mass casualty overnight and in the early morning of April 19, 2020. Community residents took active steps to share information about the mass casualty and to seek to ensure the safety of themselves and others.

Chapter 4 Events on April 19, 2020 – 6:00 am to 10:15 am

MAIN FINDING The RCMP did not treat Lisa Banfield as a surviving victim of the mass casualty; that is, as an important witness who required careful debriefing and who would need support services.

MAIN FINDING The RCMP did not provide advice to community members about what precautions they should take to ensure their safety. In the absence of this information, community members adopted a range of strategies to stay safe, some of which may have put them at greater risk.

MAIN FINDING Poor navigation technology and a lack of local geographic knowledge by responding RCMP members slowed the RCMP response to information received about the perpetrator's location.

MAIN FINDING The RCMP's failure to publicly share accurate and timely information, including information about the perpetrator's replica RCMP cruiser and disguise, deprived community members of the opportunity to evaluate risks to their safety and to take measures to better protect themselves.

MAIN FINDING Essential workers, including Victorian Order of Nurses (VON) employees, were particularly at risk because of the nature of their work. The RCMP did not share accurate and timely information, including information about the perpetrator's replica RCMP cruiser and disguise, with these workers or their employers. By not sharing this information, they deprived these essential workers and their employers of the opportunity to evaluate risks to the safety of the workers. This opportunity would have allowed them to take measures to better protect themselves.

MAIN FINDING The command post did not take sufficient steps to reassess the strategic and tactical response, even after it began to consider the possibility that the perpetrator had escaped Portapique.

MAIN FINDING The briefing of RCMP members was inadequate throughout the critical incident response and particularly during the shift change on the morning of April 19, 2020.

MAIN FINDING The RCMP did not have a clear alternative to calling 911 for the public to report concerns about family and loved ones, or to provide information that may have been significant but did not relate directly to the perpetrator's whereabouts.

MAIN FINDING The RCMP's critical incident response did not deploy resources according to a coherent and coordinated strategy. Its approach was reactive.

MAIN FINDING The RCMP directive to the Nova Scotia Medical Examiner Service not to release information about cause, manner, and circumstances of death to family members was unnecessary and harmful in the circumstances of this investigation, and it compounded the grief and mistrust of some family members.

MAIN FINDING The RCMP's H Division and national executive leadership had not predefined or practised their roles and responsibilities during a major critical incident response. As a result, their role was unclear. Opportunities for the executive leadership to support the critical incident response were overlooked.

MAIN FINDING The command group did not share information about the unfolding mass casualty with senior executive leadership in H Division or national headquarters in a timely, coordinated, or accurate way.

MAIN FINDING The lack of shared RCMP, Emergency Health Services (EHS), and firefighter protocols to ensure that non-police emergency responders are safe and able to perform their work created an uneven response in which these responders were at times exposed to greater safety risks and at other times may have been prevented from doing work that would have aided the critical incident response or subsequent investigation.

MAIN FINDING The RCMP did not systematically share information with other emergency responders, including volunteer fire services and Emergency Health Services, that would have permitted these responders to evaluate risks to their safety and take measures to better protect themselves.

MAIN FINDING Media has an important role to play in a critical incident response. The RCMP's approach of sharing information primarily via social media was insufficient to strategically engage local media outlets. The media was insufficiently utilized as a partner in public communications on April 18 and 19, 2020.

Chapter 5 Onslow Fire Hall Shooting

MAIN FINDING The command post and Operational Communications Centre did not take adequate measures to ensure that all members were aware of the location of the comfort centre and that a marked RCMP cruiser was stationed at this location. This information should have been broadcast repeatedly by radio or otherwise shared with all responding members, and it should have been acknowledged as received.

MAIN FINDING The Onslow Belmont Fire Brigade hall should have been a place of safety for community members, including those who were directly affected by the mass casualty. Fortunately, the Onslow fire hall shooting did not cause death or physical injuries, but this incident turned a place of safety into a site of further harm.

MAIN FINDING The procedure that must be followed by police after a use of potentially lethal force should not be varied during a critical incident response unless there is an immediate threat from a physically present perpetrator. This exception did not apply in the circumstances of the Onslow fire hall shooting.

MAIN FINDING The RCMP command group did not recognize the gravity of the Onslow fire hall shooting. They failed to take the necessary steps to evaluate the circumstances of the shooting, secure the scene, or evaluate the involved members' capacity to continue with the critical incident response.

MAIN FINDING In the weeks and months after the incident, the RCMP continued to underestimate the gravity of the Onslow fire hall shooting. They did not take sufficient steps to hear community concerns, nor recognize that those who were placed at risk during the shooting required support. These failures caused lasting harm to the RCMP's relationships with the Onslow community and the people at the fire hall that day.

Chapter 6 Events on April 19, 2020 – 10:15 am to Noon

MAIN FINDING Overall, the RCMP did not adopt a strategic, coordinated approach to the positioning of members while searching for the perpetrator on April 19, 2020. However, individual supervisors and risk managers tried to coordinate member positions in response to the information available to them.

MAIN FINDING The critical incident response was hindered by the inability to scale up resources in a timely fashion. The steps taken to seek additional resources were ad hoc and diverted the attention of the command post and risk managers.

MAIN FINDING Handing coordination of general duty members to the risk manager created additional difficulties in coordination between the command post and general duty members, and it further overburdened the risk managers and Operational Communications Centre.

MAIN FINDING Inadequate public communications constrained the flow of information and assistance from the public to the critical incident response.

MAIN FINDING Despite receiving information that some residents of Portapique were unaccounted for, the RCMP did not conduct a timely search for additional living or deceased victims.

MAIN FINDING In the absence of coordinated victim support arrangements, and with no organized notification process for confirmed deaths, concerned family members called 911 to both seek and provide information. These calls added to the Operational Communications Centre's workload at a very busy time in the critical incident response.

MAIN FINDING The critical incident response was hindered by a lack of coordination, communication, and interoperability between the RCMP and the Truro Police Service.

MAIN FINDING Alert Ready was the best available tool to warn the Nova Scotia public about the mass casualty and to provide updates as the information available to the RCMP changed.

MAIN FINDING The critical incident response was hindered by the failure to coordinate with key emergency management services including the Divisional Emergency Operations Centre and the provincial Emergency Management Office.

Chapter 7 Events from Noon on April 19, 2020, Onward

MAIN FINDING The RCMP's failure to find the fatalities at Cobequid Court in a timely manner resulted from inadequate RCMP scene management and an emphasis on pursuing the perpetrator at the expense of other police responsibilities.

A systematic door-to-door search was not conducted until 19 hours after the first 911 call from the Portapique community. This is an unacceptable delay.

MAIN FINDING These problems were exacerbated by the RCMP's failures to act on information shared by family members and lack of communication with concerned family members and community residents. In some instances, it took far too long for the RCMP to make next of kin notifications or provide updates to family members who were anxiously seeking information about the well-being of their loved ones.

MAIN FINDING The RCMP did not find all forensic evidence at crime scenes. In some instances, evidence was found by family members and the public (and, eventually, by Commission investigators) after crime scenes had been released.

MAIN FINDING The services offered by the RCMP and Nova Scotia Victim Services did not fully meet the needs of those families and communities most affected by the mass casualty. In the absence of a coordinated and planned approach, ad hoc attempts to scale up services were insufficient.

MAIN FINDING The RCMP's next of kin notification policy and guidelines are inadequate. These notifications were not carried out in a coordinated and timely manner. RCMP members were not adequately trained to carry out these duties with skill and sensitivity.

MAIN FINDING The RCMP did not provide adequate information services to those most affected because of systemic gaps in policy, the inadequate allocation of personnel, and the lack of provision of training for personnel charged with providing these services.

MAIN FINDING After the mass casualty, the RCMP prioritized institutional and investigative imperatives over the needs of survivors and family members. The RCMP's information-sharing practices with survivors and family members were inadequate.

MAIN FINDING Nova Scotia Victim Services did not fully meet the need for support services after the mass casualty. Gaps arose from the lack of proactive service provision and from limited navigation assistance. Support services were not adapted to address the needs and circumstances of those most affected, including the distinct needs of those who lived in Portapique. People residing outside of Nova Scotia faced additional hurdles to accessing provincially funded support services.

MAIN FINDING After the mass casualty, the RCMP public communications strategy did not provide timely and accurate information about the mass casualty and the ensuing investigation.

MAIN FINDING The RCMP did not undertake an after-action review of its response to the mass casualty.

Volume 3: Violence

PART A: THE PERPETRATOR

Introduction and Overview

MAIN FINDING There was intergenerational violence in the perpetrator's family. The perpetrator was physically and emotionally abused as a child and, as an adult, he was violent toward his father and uncle Glynn.

MAIN FINDING As an adult, the perpetrator developed an alcohol use disorder and was known to become violent when he drank to excess.

Chapter 1 Perpetrator's History of Violence and Coercion

MAIN FINDING The perpetrator's pattern of violent and intimidating behaviour was facilitated by the power and privilege he experienced as a white man with professional status and substantial means.

Chapter 2 Perpetrator's Financial History and Misdealings

MAIN FINDING The Commission cannot conclude on the available evidence that the perpetrator was a paid police informant.

MAIN FINDING The Commission cannot conclude on the available evidence that the perpetrator was involved in the purchase or sale of drugs, in money laundering, or in organized crime.

MAIN FINDING The perpetrator had a history of financial misdealings that included manipulative and predatory patterns of behaviour.

Chapter 3 Perpetrator's Acquisition of Firearms

MAIN FINDING Incomplete information sharing between the Canada Border Services Agency (CBSA) and other law enforcement agencies, including Criminal Intelligence Service Nova Scotia, meant CBSA was not able to fully assess risk factors when the perpetrator applied for a NEXUS card or when he crossed the border. The information-sharing infrastructure at that time left the CBSA with incomplete knowledge about the perpetrator.

MAIN FINDING In this context of incomplete information available to the CBSA, the risk factors that were known to the CBSA (including that the perpetrator was possibly undervaluing motorcycle parts, and that he crossed the border frequently) were not assessed holistically with other indicators of concern that were known to other agencies but not the CBSA.

MAIN FINDING The perpetrator's illegal acquisition of firearms provided him with the means to carry out the mass casualty. Despite many red flags, existing enforcement practices were ineffective in preventing the perpetrator from illegally acquiring and possessing these firearms and from smuggling them across the land border between the United States and Canada.

Chapter 4 Perpetrator's Acquisition of the Replica RCMP Cruiser and Police Kit

MAIN FINDING GCSurplus and RCMP asset management policy were inadequate for ensuring that sensitive material such as decals were fully removed from decommissioned RCMP vehicles and destroyed. These inadequacies facilitated the perpetrator's access to the means to fabricate the replica RCMP cruiser.

MAIN FINDING GCSurplus training and oversight of its warehouse employees were inadequate, particularly with respect to what steps should be taken to identify and report suspicious activity.

MAIN FINDING The perpetrator's acquisition of decommissioned police cars and police uniform and kit, and particularly his fabrication of a replica RCMP cruiser, provided him with additional means to carry out the mass casualty. Ownership of many of these elements is unregulated, although it was unlawful to possess some of the items he acquired.

MAIN FINDING Many community residents knew about the perpetrator's replica RCMP cruiser, but no one reported its existence to authorities.

Chapter 5 Interactions with Police and Other Authorities

MAIN FINDING The perpetrator's violence and illegal firearms came to the attention of police on repeated occasions in the years prior to the mass casualty. Due to a number of structural and systemic problems, these serious allegations regarding a single individual did not prompt an appropriate police response. These structural problems are: implicit bias in police decision-making, failure to identify and address gender-based violence, the lack of effective investigation by the police forces, the lack of detailed notes by RCMP members and ineffective supervision, the short period of record retention, the siloing of information between agencies, whether due to different database systems or failure to share information, and lack of effective communication between the HRP, the Truro Police, and the RCMP.

Chapter 6 Missed Intervention Points

MAIN FINDING Despite widespread community knowledge of the perpetrator's violent and otherwise illegal, intimidating, and predatory behaviour over a number of years, there were impediments to safely reporting concerns, including a fear of retaliation, ineffective access points, and a lack of faith in an adequate police response. These impediments were magnified by the operation of power and privilege, and by a lack of trust and confidence in police and other authorities, particularly for members of marginalized communities. The barriers to reporting resulted in missed red flags and opportunities to intercede in his behaviour.

LESSON LEARNED A cultural shift is required so that (a) our institutions accommodate accessible, safe, and credible reporting mechanisms; (b) promoting crime prevention and community safety becomes a shared responsibility; and (c) existing systemic biases favouring privileged perpetrators are addressed.

PART B: MASS CASUALTY INCIDENTS

Chapter 7 The Study of Mass Casualty Incidents

LESSON LEARNED A clear data-collection, research, and policy strategy is necessary to build our understanding of mass casualty incidents. This strategy must be centred on widespread acceptance of a common definition to facilitate tracking and research. The definition must address existing gender bias and permit research and policy exploration of the links between mass casualty incidents and gender-based violence, intimate partner violence, and family violence.

Recommendation V.1

FRAMEWORK FOR TRACKING MASS CASUALTY INCIDENTS

The Commission recommends that

(a) All individuals and entities engaged in data-collection research and policy development, including law enforcement agencies and other authorities, adopt this definition of a mass casualty incident:

> An intentional act of violence during which one or more perpetrator(s) physically injure(s) and/or kill(s) four or more victims, whether or not known to the perpetrator, during a discrete period of time.

(b) All individuals and entities engaged in data-collection research and policy development, including law enforcement agencies and other authorities, collect data on the following:

(i) Information about the perpetrator, including but not limited to:

- whether the perpetrator had a history of violence, including coercive control, sexual assault, uttering threats, and criminal harassment (stalking); whether those behaviours were reported or not; whether charges were laid or not; outcome of criminal charges;
- whether the perpetrator had a history of hate-based crimes or expressing hateful sentiments toward an identified group; whether

reported or not; whether charges were laid or not; outcome of charges;

- whether the perpetrator had a history of extremism or connection to extremist movements or online forums;
- whether the perpetrator had a history of suicide attempts or suicidal ideation;
- whether the perpetrator had a history of harming or killing pets or animals, or threatening to do so;
- whether the perpetrator had a history of deliberately causing damage to property;
- whether the perpetrator had a history of being subjected to or witnessing family violence;
- whether the perpetrator had a history of alcohol and/or substance dependence;
- whether and how the perpetrator explained the mass casualty;
- whether the perpetrator had a manifesto and the contents thereof; and
- the connection, if any, between the perpetrator and the victims.

(ii) Information about access to weapons and ammunition, including but not limited to:

- specific weapons/firearms used;
- how the weapons/firearms were acquired; whether lawfully or unlawfully acquired and kept;
- the amount of ammunition the perpetrator had access to or had stockpiled;
- how ammunition was acquired; and
- history of weapons-related charges or complaints; whether criminal charges were laid or not; outcome of charges.

(iii) Information about the trajectory of the incident, including but not limited to:

- the pathway to the incident, including whether the perpetrator shared information about the plans and if so by what means and with whom ("leakage"); whether this information was reported or otherwise came to authorities' attention; whether such reports were acted on and if so, how;
- the location of the mass casualty, including whether the attack began in one place and moved to another or others;
- the perpetrator's relationship with the place where the mass casualty incident happened;
- the duration of the active phase of the mass casualty incident; and
- the means by which the mass casualty incident ended.

Chapter 8 Psychology of Perpetrators

MAIN FINDING The focus of efforts to prevent mass casualties should be on studying patterns of behaviour and addressing the root causes of mass violence rather than seeking to predict the risk presented by specific individuals.

LESSON LEARNED Community safety can be improved through community-wide public health approaches. Such approaches include (1) intervening to support and redirect those at risk of perpetrating mass violence; and (2) addressing the root causes of violence.

Recommendation V.2

A PUBLIC HEALTH APPROACH TO PREVENTING MASS CASUALTY INCIDENTS

The Commission recommends that

Strategies for prevention of mass casualty incidents should adopt public health approaches that are complex, nuanced, and community-wide while also addressing the perspectives, experience, and needs of marginalized communities.

LESSON LEARNED Forensic psychological autopsies and other forms of forensic psychological assessment are useful to the extent that they adhere to best practices. Canadian behavioural sciences units and forensic psychologists must be aware of and attend to the operation of bias, stereotypes, and victim blaming in this field.

Recommendation V.3

EXTERNAL EVALUATION OF RCMP BEHAVIOURAL SCIENCES BRANCH

The Commission recommends that

(a) The RCMP commission an expert external evaluation of the Behavioural Sciences Branch to assess the extent to which its policies, procedures, personnel, and work product:

  (i) reflect the best practices set out in Volume 3, Chapter 8 of this Final Report; and

  (ii) are attentive to, and effectively counter, the potential operation of bias, stereotypes, and victim blaming.

(b) The external evaluation should also make recommendations as to how the Behavioural Sciences Branch can improve its policies, procedures, practices, and training to implement best practices; identify and counter the operation of stereotypes and victim blaming; and ensure that the

failings documented in this Final Report are not replicated in the future work of the Branch.

(i) This evaluation, and the steps taken by the RCMP to respond to the evaluation, should be published on the RCMP's website.

(ii) Other law enforcement agencies should review the completed evaluation and implement both the lessons learned and the best practices into the behavioural sciences aspect of their mandates.

Recommendation V.4

PERIODIC REVIEW OF RCMP BEHAVIOURAL SCIENCES BRANCH

The Commission recommends that

(a) The RCMP periodically obtain an expert external evaluation of the Behavioural Sciences Branch's work to ensure that this work:

(i) reflects the best practices set out in Volume 3, Chapter 8, of this Final Report; and

(ii) is attentive to, and effectively counters, the potential operation of bias, stereotypes, and victim blaming.

(b) These evaluations, and the steps taken by the RCMP to respond to them, should be published on the RCMP's website.

Recommendation V.5

CONFLICT OF INTEREST IN FORENSIC PSYCHOLOGICAL ASSESSMENT

The Commission recommends that

Where a forensic psychological assessment has the potential to shed light on the death of a police officer or may affect evaluations of the quality of a police agency's work, that assessment should be completed by an independent forensic psychologist or unit. In this context, independence means that the psychologist or unit has no historical or present employment or reporting relationship with the police agency concerned, and that measures to prevent bias are put in place.

Chapter 9 Sociology of Mass Casualty Incidents

MAIN FINDING While violence is overwhelmingly perpetrated by men, most men do not perpetrate violence. However, mass casualties are a gendered phenomenon. Mass casualty incidents are committed almost universally by men. By whatever measure we use, most serious violence in North America is committed by men and boys. This includes violence against strangers, violence against family members and intimate partners, and mass casualties. Gun ownership, gun-related fatalities, and gun violence more generally are all gendered phenomena.

MAIN FINDING As a result of gender bias, the strong connection between gender-based violence and mass casualties continues to be overlooked in much research and commentary, and in measures to prevent and respond to violence, including to mass casualty incidents.

PART C: PREVENTING MASS CASUALTY INCIDENTS

Chapter 10 Collective and Systemic Failure to Protect Women

MAIN FINDING Gender-based, intimate partner, and family violence is an epidemic. Like the COVID-19 pandemic, it is a public health emergency that warrants a meaningful, whole of society response.

MAIN FINDING Although experienced by all genders, these forms of violence affect a disproportionately large number of women and girls. The impact is even more severe on some communities of women and girls marginalized within Canadian society: Indigenous women and girls; Black and racialized women and girls; immigrant and refugee women and girls; Two-Spirit, lesbian, gay, bisexual, transgender, queer, intersex, and additional sexually and gender diverse (2SLGBTQI+) people; people with disabilities; and women living in northern, rural, and remote communities.

MAIN FINDING Economic marginalization and criminalization heighten the risk of violence against women and girls.

MAIN FINDING The COVID-19 pandemic has intensified rates of gender-based violence worldwide.

MAIN FINDING The RCMP's treatment of Lisa Banfield during the RCMP's H-Strong investigation is an example of the kind of revictimization that makes it less likely that women survivors of gender-based violence will seek help from police.

The victim blaming and hyper-responsibilization (holding of an individual to higher standards than what would typically be expected of the average person) to which Ms. Banfield was subjected by community members reflect myths about "triggers" in a mass casualty and that a woman is responsible for her partner's actions. This reaction also has a chilling effect on other survivors of gender-based violence.

LESSON LEARNED Active steps need to be taken by police and Crown counsel to ensure fair treatment of women survivors and to end inadvertently discouraging women from reporting gender-based violence.

Recommendation V.6

INTIMATE PARTNER VIOLENCE AND POLICE AND PROSECUTORIAL DISCRETION TO LAY CRIMINAL CHARGES

The Commission recommends that

(a) Police and Crown attorneys / counsel carefully consider the context of intimate partner violence, and particularly coercive control, when criminal charges are being contemplated against survivors of such violence; and

(b) Police investigations and public prosecutions should engage subject matter experts to help ensure that the dynamics of intimate partner violence are understood.

LESSON LEARNED Active steps must be taken to counter myths and stereotypes about "triggers" in mass casualties and victim blaming and hyper-responsibilization of women survivors of gender-based violence.

Recommendation V.7

COUNTERING VICTIM BLAMING AND HYPER-RESPONSIBILIZATION OF WOMEN SURVIVORS

The Commission recommends that

Federal, provincial, and territorial governments work with and support community-based groups and experts in the gender-based advocacy and support sector to develop and deliver prevention materials and social awareness programs that counter victim blaming and hyper-responsibilization (holding of an individual to higher standards than what would typically be expected of the average person) of women survivors of gender-based violence.

Chapter 11 Keeping Women Unsafe

MAIN FINDING Police use of risk assessment tools in situations of intimate partner violence is inadequate and, moreover, they are applied unevenly by different police forces across Canada.

MAIN FINDING The gender-based violence advocacy and support sector is working to deepen our contextualized understanding of risk factors through a variety of initiatives, including domestic homicide reviews, action research projects that include interviews and collaborations with survivors, research into specific issues such as the role of pets and livestock ownership in risk assessments, and development of risk assessment tools that can be used by women themselves and by organizations that serve them.

LESSONS LEARNED

Our understanding of risk factors for intimate partner violence has grown but must be continually deepened and expanded.

- Broad public understanding of risk factors, including systemic factors, will contribute to prevention. Risk assessment tools should have a dual aim of ensuring an effective response to immediate threats and long-term protection.
- Risk assessment tools can be used by women themselves and in many other contexts, such as health and social service provision, workplaces and schools, women-serving organizations, men-serving organizations, and law enforcement.
- Standardized frameworks for assessments are valuable but must be adaptable to diverse contexts.
- The use of risk assessment tools needs to be continually monitored and evaluated.

Recommendation V.8

WOMEN-CENTRIC RISK ASSESSMENTS

The Commission recommends that

(a) The federal government should initiate and support the development of a common framework for women-centric risk assessments through a process led by the gender-based violence advocacy and support sector.

(b) All agencies responsible for the development and application of risk assessment tools integrate this common framework into their work in collaboration with the gender-based violence advocacy and support sector and on the basis of direct input from women survivors.

(c) The common framework and the risk assessment tools built on this framework have a dual aim of ensuring an effective response to immediate threats and long-term protection.

IMPLEMENTATION POINTS

- We support the adoption and implementation of the Renfrew County Inquest jury recommendation 41:

  > 41. Investigate and develop a common framework for risk assessment in IPV [intimate partner violence] cases, which includes a common understanding of IPV risk factors and lethality. This should be done in meaningful consultation and collaboration with those impacted by and assisting survivors of IPV, and consider key IPV principles, including victim-centred, intersectional, gender-specific, trauma-informed, anti-oppressive, and evidence-based approaches.

- The common framework should be based on work done by the gender-based violence and advocacy sector, including on
  - the identification of risk factors and the integration of contextualized knowledge about the patterns of perpetration, women's perspectives and experiences; and

- systemic factors that contribute to risk assessment tools used by all agencies, including the police, primarily to assist women to develop and carry out effective safety plans for themselves, their children, and other dependants (family members, pets, and livestock).

MAIN FINDING The unacceptably low rate of reporting of gender-based violence is a result of factors such as systemic barriers rooted in the criminal justice system and the operation of racism, gender-based myths, and stereotypes; the complex interactions among the criminal, family law, and immigration law regimes; and the fact that these systems do not adequately take into account the reality of women's lives. Many women fear disbelief by others, including the police, do not trust that police will ensure their safety, and are concerned about being criminalized or subject to other state harms. These barriers are heightened for marginalized women survivors.

LESSON LEARNED New community-based systems for reporting gender-based violence must be developed to respond to the safety needs articulated by women. Specific attention must be paid to the needs of marginalized women survivors and the needs of other women who are vulnerable as a result of their precarious status or situation.

Recommendation V.9

CREATING SAFE SPACES TO REPORT VIOLENCE

The Commission recommends that

(a) Governments, service providers, community-based organizations, and others engaged with the gender-based violence advocacy and support sector take a systemic approach to learning about and removing barriers to women survivors, with a focus on the diverse needs of marginalized women survivors and the needs of other women who are vulnerable as a result of their precarious status or situation.

(b) Community-based organizations, supported by governments, should develop safe spaces suited to their community needs in which women can report violence and seek help.

(c) Community-based reporting systems should include the capacity to move beyond individual incidents and identify and address patterns of violent behaviour.

(d) Community-based reporting systems should be linked with the police in a manner that takes into account the input and needs of women survivors.

MAIN FINDING Mandatory arrest and charging policies and protocols have often failed to keep women safe and have resulted in unintended harms that in some cases endanger women.

LESSON LEARNED Mandatory arrest and charging policies and protocols for offences arising from intimate partner violence should be abolished and replaced by a new women-centred framework that focuses on violence prevention rather than a carceral response.

Recommendation V.10

REPLACEMENT OF MANDATORY ARREST AND CHARGING POLICIES AND PROTOCOLS FOR INTIMATE PARTNER VIOLENCE OFFENCES

The Commission recommends that

(a) Provincial and territorial governments replace mandatory arrest and charging policies and protocols for intimate partner violence offences with frameworks for structured decision-making by police, with a focus on violence prevention.

(b) The federal government initiate and support a collaborative process that brings together the gender-based violence advocacy and support sector, policy-makers, the legal community, community safety and law enforcement agencies, and other interested parties to develop a national framework for a women-centred approach to responding to intimate partner violence, including structured decision-making by police that focuses on violence prevention.

(c) Provincial and territorial governments, working with gender-based violence advocacy and support sectors, develop policies and protocols for implementing this national framework to address jurisdiction-specific needs.

IMPLEMENTATION POINT

- One model worth exploring in planning the national initiative is the approach taken in the development of the Canadian Framework for Collaborative Police Response on Sexual Violence.

MAIN FINDING Sexist and racist myths and stereotypes continue to result in ineffective and inconsistent responses by police services to gender-based violence – in particular to intimate partner violence and sexual assault cases.

LESSON LEARNED External accountability mechanisms are required to counter the prevalent sexist and racist myths and stereotypes about gender-based violence that result in largely ineffective and inconsistent police responses.

Recommendation V.11

EXTERNAL ACCOUNTABILITY MECHANISM FOR POLICING RESPONSES TO INTIMATE PARTNER VIOLENCE

The Commission recommends that

(a) The federal government support the gender-based violence advocacy and support sector to work with police services to expand upon the National Framework for Collaborative Police Action on Intimate Partner Violence.

(b) This framework should include an external accountability mechanism.

IMPLEMENTATION POINT

- The Improving Institutional Accountability Project model or a similar model should be considered.

MAIN FINDING Coercive control is a pattern of violent behaviour exercised by a member of intimate partner or familial relationships that is clearly problematic and poorly understood in Canadian society, including by the police. Misconceptions about the nature of coercive control and the harms that result from this behaviour contribute to a lack of effective prevention, interventions, and responses.

LESSON LEARNED A multifaceted approach is required to enable effective prevention of, intervention in, and responses to coercive control.

Recommendation V.12

EFFECTIVE APPROACHES TO ADDRESSING COERCIVE CONTROL AS A FORM OF GENDER-BASED INTIMATE PARTNER AND FAMILY VIOLENCE

The Commission recommends that

(a) Federal, provincial, and territorial governments establish an expert advisory group, drawing on the gender-based violence advocacy and support sector, to examine whether and how criminal law could better address the context of persistent patterns of controlling behaviour at the core of gender-based, intimate partner, and family violence.

(b) The federal government amend the *Criminal Code* to recognize that reasonable resistance violence by the victim of a pattern of coercive and controlling behaviour is self-defence.

(c) Where they have not already done so, provincial and territorial governments amend their family law statutes to incorporate a definition of family violence that encompasses patterns of coercive and controlling behaviour as a factor to be considered in proceedings under these statutes.

(d) All provincial and territorial governments work collaboratively with the gender-based violence advocacy and support sector, policy-makers, the legal community, community safety and law enforcement agencies, and other interested parties to develop educational and public awareness campaigns about coercive control.

IMPLEMENTATION POINT

- We support the adoption and implementation of the Renfrew County Inquest jury recommendation 38:

  > Ensure that IPV [intimate partner violence]-related public education campaigns address IPV perpetration and should include men's voices, represent men's experiences, and prompt men to seek help to address their own abusive behaviours. They should highlight opening the door to conversations about concerning behaviours.

MAIN FINDING Funding related to preventing and effectively intervening in gender-based violence has been inadequate for many years and, for that reason, endangers women's lives.

LESSONS LEARNED

- Community-based services, and in particular services provided by the gender-based violence advocacy and support sector, need to be viewed in tandem with police agencies as equal partners in preventing violence. These services are front-line public services and are not discretionary.
- Project-based funding is inefficient and causes lapses in effective preventive and support services. Adequate and stable core funding is essential for efficient and effective operation of all organizations forming part of the public safety net in Canada.

Recommendation V.13

EPIDEMIC-LEVEL FUNDING FOR GENDER-BASED VIOLENCE PREVENTION AND INTERVENTIONS

The Commission recommends that

Federal, provincial, and territorial funding to end gender-based violence be commensurate with the scale of the problem. It should prioritize prevention and provide women survivors with paths to safety.

IMPLEMENTATION POINTS

- Funding should be adequate and include stable core funding for services that have been demonstrably effective in meeting the needs of women survivors of gender-based violence and that contribute to preventing gender-based violence, including interventions with perpetrators.
- These services should be funded over the long term and should not be discontinued until it has been demonstrated that the services are no longer required or an equally effective alternative has been established.
- Priority should be placed on providing adequate and stable core funding to organizations in the gender-based violence advocacy and support sector.
- A further priority should be funding community-based resources and services, particularly in communities where marginalized women are located.

Chapter 12 It Is Time: A Collective Responsibility to Act

Recommendation V.14

MOBILIZING A SOCIETY-WIDE RESPONSE

The Commission recommends that

(a) All levels of government in Canada declare gender-based, intimate partner, and family violence to be an epidemic that warrants a meaningful and sustained society-wide response.

(b) Non-governmental bodies, including learning institutions, professional and trade associations, and businesses, declare gender-based, intimate partner, and family violence to be an epidemic that warrants a meaningful and sustained society-wide response.

(c) Men take up individual and concerted action to contribute to ending this epidemic.

IMPLEMENTATION POINTS

- A whole of society response recognizes the range of actors that have roles and responsibilities to contribute to ending this epidemic, including: federal, provincial, territorial, municipal, and Indigenous governments; the health sector and the justice system; the non-governmental and community-based social services sector; businesses, and workplaces; media; schools and educational institutions; communities; and individuals, including survivors and perpetrators.
- A whole of society response respects and values the expertise and experience of survivors and the gender-based violence advocacy and support sector.

Recommendation V.15

WOMEN-CENTRED STRATEGIES AND ACTIONS

The Commission recommends that

(a) All organizations and individuals adopt women-centred strategies and actions to prevent, intervene in, and respond to gender-based violence, and to support restoration and healing;

(b) Women-centred strategies and actions be facilitated through the development and support of holistic, comprehensive, coordinated, collaborative, and integrated advocacy, support, and services.

(c) Women-centred solutions focus foremost on taking active steps to listen to, learn from, and situate the most marginalized and oppressed women and women living in precarious circumstances.

IMPLEMENTATION POINTS

- Recognition of the expertise and experience of the gender-based violence advocacy and support sector, including survivors of gender-based violence, is essential.

- No effective solutions can be developed without input from the people for whom they are being developed.
- Tailored solutions are required in recognition that there is no effective "one size fits all" approach.
- Institutional and personal dynamics that result in silencing women must be actively noticed, identified, resisted, and remedied.
- Women should be seen as members of communities rather than in purely individualistic terms.
- Approaches should affirm and support women's agency.

Recommendation V.16

PUTTING WOMEN'S SAFETY FIRST

The Commission recommends that

(a) All governments and agencies should prioritize women's safety in all strategies to prevent, intervene in, and respond to gender-based violence and in those designed to support recovery and healing.

(b) Governments should shift priority and funding away from carceral responses and toward primary prevention, including through lifting women and girls out of poverty and supporting healthy masculinities.

(c) Governments should take steps to ensure women are resourced so they can stay safe and find paths to safety when they are threatened, including by lifting women and girls out of poverty with a focus on marginalized and oppressed women and women living in precarious situations.

(d) Governments should employ restorative approaches in cases where a woman-centred approach is maintained and survivors are adequately supported and resourced.

Recommendation V.17

NATIONAL ACCOUNTABILITY FRAMEWORK

The Commission recommends that

(a) The federal government establish by statute an independent and impartial gender-based violence commissioner with adequate, stable funding, and effective powers, including the responsibility to make an annual report to Parliament.

(b) The federal government develop the mandate for the gender-based violence commissioner in consultation with provincial and territorial governments, women survivors including women from marginalized and precarious communities, and the gender-based violence advocacy and support sector.

IMPLEMENTATION POINTS

The commissioner's mandate could include:

- Working with governments and community organizations to promote coordinated, transparent, and consistent monitoring and evaluation frameworks.
- Providing a national approach to victim-survivor engagement, to ensure their diverse experiences inform policies and solutions (similar to the Australian Domestic, Family and Sexual Violence Commission).
- Developing indicators for all four levels of activity (individual, relational, community, societal) and reporting to the public at least once a year.
- Establishing and working with an advisory committee that consists of women survivors, particularly marginalized women survivors, and representatives of the gender-based violence advocacy and support sector.
- Contributing to a national discussion on gender-based violence, including by holding biannual virtual women's safety symposiums.
- Assisting to coordinate a national research agenda and promoting knowledge sharing.

Volume 4: Community

PART A: RURALITY AND RURAL COMMUNITIES

Chapter 3: Rural Communities and Well-being

LESSONS LEARNED Rural community well-being is constrained by limited access to services, poverty, and under-inclusion, and in some cases, this negatively affects the occupational health and safety of rural service providers.

Urban bias in policy-making and service delivery contributes to inadequate public infrastructure and services in rural communities.

Recommendation C.1

STRENGTHENING RURAL WELL-BEING THROUGH INCLUSION

The Commission recommends that

(a) Provincial and territorial governments should take steps to address urban bias in decision-making by fostering meaningful inclusion of rural communities in all areas affecting them.

(b) The federal government should support the inclusion of rural communities in decision-making on issues within their jurisdiction.

PART B: COMMUNITY-CENTRED CRITICAL INCIDENT RESPONSES

Chapter 4: Framework for Community-Centred Responses

MAIN FINDING Mass casualty incidents have a circle of impact that extends beyond those whose lives were taken and those who are injured. This broader circle encompasses families and friends of the deceased and injured survivors; others present during the incident, including emergency responders and other service providers; local communities; and the wider population.

The nature and extent of the impact will vary within this circle, and a differential impact has been shown to exist for individuals and groups who have specific needs as a result of personal characteristics and experience or are members of historically and contemporaneously marginalized or stigmatized groups.

MAIN FINDINGS Both directly and indirectly affected individuals can experience a range of negative mental and physical health outcomes following a mass casualty incident. Grief and bereavement are normal, healthy processes, and these processes can be facilitated through increased grief literacy and other forms of formal and informal support. Traumatic loss can lead to complicated grief and a range of post-traumatic stress injuries, including PTSD. Mass casualties can also result in vicarious, secondary, and collective trauma.

MAIN FINDINGS The Norwegian Aftermath Study provides a strong empirical base for understanding the needs experienced by those most affected by mass casualty incidents. This study clearly demonstrates the persistence of need for financial support, material support, and educational support for survivors of the Utøya mass casualty and their families.

Eight years after the incident, many people from among this group were still experiencing high levels of PTSD, clinical levels of anxiety and depression, physical health challenges, difficulties sleeping, and impaired daily functioning. Levels of unmet need increased over time, and unresolved trauma experiences resulted in an increase in consumption of primary healthcare services both in the early and delayed aftermath. Survivors of minority background and young survivors were differentially affected, experiencing profound long-lasting effects.

MAIN FINDINGS The objectives of post–mass casualty incident assistance should be to support the coping capabilities of individuals, families, and communities so as to enable them to recover, to the greatest extent possible, and to foster resilience despite traumatic loss.

LESSONS LEARNED Mass casualty incidents are high-impact events that occur infrequently, making it difficult for public safety organizations to develop expertise and train personnel to provide trauma-informed and victim-centred services.

Recommendation C.2

NATIONAL RESOURCE HUB FOR MASS CASUALTY RESPONSES

The Commissions recommends that

The federal government should establish, by September 2023, a National Resource Hub for Mass Casualty Responses with a mandate to:

(a) serve as a centre of expertise for the provision of services to victims and affected persons, including families and friends of victims, during and after a mass casualty;

(b) draw on national and international experience, research, and promising practices;

(c) build capacity across all levels of government to plan responses to future mass casualty incidents and respond effectively to victim needs in the short, medium, and long term, including through the development of draft protocols, training modules, handbooks, and other resources, and a database of experts;

(d) assist in the development of a standard of victim response across jurisdictions in Canada, while building in flexibility to respond in ways appropriate to the specific community; and

(e) facilitate the provision of assistance to victims, family members, and other affected persons who reside outside the jurisdiction where the mass casualty took place (whether in Canada or in another country) and

facilitate assistance to foreign victims and affected persons, including, for example, through cross-border support service referrals.

IMPLEMENTATION POINTS

- The federal government should consult the Canadian Association of Chiefs of Police National Working Group Supporting Victims of Terrorism and Mass Violence; their relevant Indigenous, provincial, and territorial counterparts; the Canadian Resource Centre for Victims of Crime; other victims' rights advocacy organizations; provincial victims' services programs; and the Federal Ombudsman for Victims of Crime.
- The expertise developed by this National Resource Hub for Mass Casualty Responses could extend to other types of emergency and major incident response.
- The National Resource Hub could also assist directly in training personnel, and could potentially establish a small national team to be mobilized quickly in response to a mass casualty.

Chapter 5: Public Warning Systems

Recommendation C.3

AMENDING THE CANADIAN DISASTER DATABASE TO INCLUDE MASS CASUALTY INCIDENTS

The Commission recommends that

The Minister of Public Safety Canada amend the categories of events used in the Canadian Disaster Database to include mass casualty incidents as defined in Recommendation V.1: "An intentional act of violence during which one or more perpetrator(s) physically injure(s) and/or kill(s) four or more victims, whether or not known to the perpetrator, during a discrete period of time."

LESSONS LEARNED Alert Ready is circumscribed by challenges and limitations that exist beyond the systemic failures of the RCMP to consider its use during the mass casualty.

A fundamental review and redesign of the national public alert system is required.

A community-centred system of alert systems is required to fully meet public needs.

Recommendation C.4

FUNDAMENTAL REVIEW OF ALERT READY

The Commission recommends that

The federal, provincial, and territorial governments should undertake a fundamental review of public emergency alerting to determine whether and how the Alert Ready system can be reformed in such a way that it meets the legal responsibility to warn the population of an emergency that threatens life, livelihoods, health, and property.

This joint governmental review of the national public alerting system should be comprehensive and at a minimum address the following:

(a) It should include substantive community and stakeholder engagement at all stages.

(b) It should establish a national framework for public alerting, led by Public Safety Canada, with operationalization to continue on a provincial, territorial, and Indigenous government basis but pursuant to national standards. It should restructure in order to transition from reliance on a private corporation as the provider of Canada's national alerting system.

(c) It should be completed in advance of and inform the next round of negotiations with the licensee / candidates and be taken into consideration in any renewal issued before the completion of the review.

(d) It should be based on the following system design principles: centring the public; building a system of systems; enhancing governance; formulating a concept of operations; protecting privacy; focusing on preparedness;

assuring equality and inclusiveness; and promoting continuous learning and improvement.

(e) It should include a comprehensive review of communications interoperability across the public safety system.

IMPLEMENTATION POINT

- Consideration should be given to the value of establishing a national emergency management system.

LESSON LEARNED Effective public alert systems require an ongoing iterative learning process.

Recommendation C.5

TRIENNIAL REVIEW OF THE NATIONAL PUBLIC ALERTING SYSTEM

The Commission recommends that

The senior officials responsible for emergency management undertake a review of the national public alerting system every three years and that a report on the process and findings of this review be made public.

The review include a public-engagement component, including a national poll about the awareness and assessment of the national public alerting system.

The review take into consideration the diverse needs of people living in Canada, including urban, rural, and remote communities, official language minorities, and marginalized communities.

Chapter 6: Meeting the Needs of Survivors and Affected Persons: Police-Based Services

LESSONS LEARNED Ensuring that the basics of victim support are solidly in place and that interoperability between emergency responders is effective and well-established will enable the scaling up of critical incident response in the event of a mass casualty.

Numerous previous inquiries, reviews, and reports have identified inadequacies and limitations in the RCMP provision of information and other services to victims and other affected persons.

RCMP policies and training with respect to next of kin notifications and the role of family liaison officers are inadequate.

RCMP institutional culture should value services provided to survivors and affected persons as significant police work essential to public safety and community well-being.

Advance planning is required to scale up victim services to meet the needs of survivors and other affected persons during and after a critical incident. Additional protocols and expertise are required to meet the demands resulting from these incidents.

Recommendation C.6

REVITALIZING POLICE-BASED VICTIM SERVICES WITH A DUTY OF CARE

The Commission recommends that

(a) The RCMP and other police services adopt policies recognizing a duty of care in the provision of services to survivors and affected persons.

(b) All police personnel communicating with survivors and affected persons do so pursuant to trauma-informed and victim-centred principles, and that they receive the education, mentoring, and support required to integrate these principles effectively.

(c) RCMP policies, protocols, and training recognize the priority of providing to survivors and affected persons full and accurate information at the earliest opportunity, including through regularly scheduled contact updates even where there is no new information to provide.

(d) Any holdback of information for investigative purposes should be limited in time and scope to that which is truly necessary to protect investigative integrity.

(e) The RCMP update its description of the role and responsibilities of family liaison officers in consultation with subject matter experts and integrating lessons learned and feedback received from Participants at the Commission.

(f) The RCMP should review and revise its next of kin notification policy and protocols and design an education module to facilitate its implementation.

(g) The RCMP take steps necessary to ensure these policies and their implementation fully meet or exceed Nova Scotia policing standards.

IMPLEMENTATION POINTS

- Preservation of victim dignity should be a priority, including through taking steps to ensure victim's bodies are secured, covered as quickly as possible, and protected such that video footage and photographs cannot be taken.
- RCMP policies, protocols, and training should recognize that in order for the family liaison officer to succeed, their colleagues (e.g., those in the Major Crimes Unit) must support them by providing accurate and timely information.
- A family liaison officer should offer meaningful updates and guidance about the investigation, as well as general information on related offices and services—including, but not limited to, the medical examiner, insurance, crime scene and evidence cleaning, and mental and physical health supports.

LESSONS LEARNED The provision of information and services to survivors and affected persons is an indispensable part of community-centred critical incident responses and should be integrated into critical incident planning and management.

Services for survivors and affected persons cannot be scaled up during or in the immediate aftermath of a critical incident without preplanning and preparedness, including through education and table-top exercises as required.

During a critical incident, the communication of information flows in two directions: from the public safety system to individuals, families, and the communities, and vice versa.

Recommendation C.7

POLICE-BASED SERVICES FOR PERSONS AFFECTED BY MASS CASUALTIES

The Commission recommends that

(a) Critical incident command groups should include a member dedicated solely to victim management and that the critical incident plan include a victim crisis response component to meet the information needs of survivors and affected persons during a major event or emergency.

(b) The victim crisis response should include: a dedicated telephone line for individuals seeking information about family or friends; a website platform; a multidisciplinary victim response team; and protocols and guidelines, including for the establishment of a family assistance centre.

(c) The time standard for mobilizing the victim management response plan should be 90 minutes from the time a critical incident response is activated.

(d) Victim management response should be a component of annual table-top critical incident response preparedness exercises.

(e) Upon request, the National Resource Hub for Mass Casualty Responses (Recommendation C.2) assist municipal police forces to build their

capacity to activate a victim management response to a critical incident, including by developing model protocols, a website plan, training modules, and other tools.

Chapter 7: Meeting the Needs of Emergency Responders

MAIN FINDING Many emergency responders, including first responders such as police, firefighters, paramedics, and other emergency health personnel, work in high psychological risk environments on a daily basis. Proactive and preventive approaches are required to mitigate these risks and to help prepare responders for the potential impact of critical incidents.

MAIN FINDING Perceived organizational support is the extent to which employees feel that their organization values their work and cares for their well-being. Where an emergency responder perceives a lack of organizational support, they are at a higher risk of experiencing post-traumatic stress symptoms.

MAIN FINDING Emergency responders have a tendency to deny and downplay the need for support and delay help-seeking behaviour. Stigma, lack of awareness of support resources, lack of confidentiality, and stoicism are obstacles to healthy help-seeking behaviour.

LESSONS LEARNED Planning for and taking steps to ensure the wellness of emergency responders as they carry out their everyday duties and to prepare them for the heightened stress and potential trauma of high-impact events is an important aspect of community-centred critical incident response.

Proactive and preventive wellness approaches should be holistic and engage a whole-of-agency discussion.

Public safety agency leadership has a critical role to play in ensuring that all responders are accorded equal organizational support and in prioritizing the eradication of barriers to healthy help-seeking behaviour.

Recognizing that families of emergency responders are affected and that experiences and family dynamics may change over time, the education about wellness and awareness of organizational supports must be continuous.

Recommendation C.8

PROACTIVE PRE-CRITICAL INCIDENT WELLNESS PLANNING

The Commission recommends that

(a) All public safety agencies should develop and promote pre-critical incident wellness planning.

(b) All public safety agencies should develop wellness programming that is proactive and preventive in nature.

(c) The leadership of public safety agencies should take proactive steps to ensure that all responders are accorded equal organizational support and to promote healthy help-seeking behaviour.

(d) Public safety agencies in each jurisdiction should collaborate to provide training, including tabletop exercises, to civilian members of the responder community, including volunteers, as one aspect of their pre–critical incident planning.

IMPLEMENTATION POINTS

Proactive and preventive wellness programs should address the following areas:

- pre-critical incident planning and training;
- integrated and intensive training to develop skills and build awareness about mental wellness (such as the Before Operational Stress Program and breathing techniques to modulate stress);
- enhanced mental health training for supervisors and officers, to promote cultural change;
- peer support programs, supported by evidence-based training, that take hierarchy into account, matching experience to experience, and ensure that a diversity of peer supporters are available to connect;
- effective informal peer support and for peer support to spouses and families of responders;

- readily available information and knowledge about the resources for peers; and
- active facilitation of help-seeking behaviour, including by:
  - addressing stigma;
  - increasing and ongoing awareness about resources;
  - enhancing confidential options;
  - raising awareness about problematic forms of stoicism;
  - openly acknowledging the difficult work;
  - promoting effective workplace policies making supports available, including in the discussion those who should play a role in these support systems; and
  - providing evidence-based supports.

MAIN FINDING Due to systemic inadequacies and limitations, Nova Scotia public safety agencies did not fully meet the needs of all emergency responders who attended to the April 2020 mass casualty and its aftermath. The experience has been highly varied: Some responders report being highly satisfied with the services received and others continue to have unmet needs for support services.

MAIN FINDING Some emergency responders, and particularly volunteer firefighters and Operational Communications Centre personnel, have chronic unmet needs for support services.

MAIN FINDING Many emergency responders continue to be affected by their experience during and after the mass casualty. Evidence from other mass casualty incidents suggests that these effects can last for many years.

LESSONS LEARNED Many emergency responders require support and wellness services following a mass casualty. Access to these services depends upon the capacity of the agency, and this capacity is not always aligned with the needs of emergency responders. The effects of a mass casualty may compound pre-existing traumas often inherent in an emergency responder's work.

Cultural and institutional factors can hinder emergency responder support-seeking strategies both on an everyday basis and in response to critical incidents.

Mass casualty incidents create additional challenges to the ability of agencies and organizations to provided support services to emergency responders. These challenges result from the scale and nature of these incidents and the cross-agency response required to meet them.

Recommendation C.9

POST–MASS CASUALTY INCIDENT EMERGENCY RESPONDER MENTAL HEALTH LEAD

The Commission recommends that

Immediately following a mass casualty incident, the provincial government should appoint a mental health point person to coordinate the mental health leads in each division or agency that responded to the incident. This liaison role would have the responsibility to oversee and evaluate the provision of confidential support services to emergency responders from all agencies and the informal sector, and to promote their wellness.

IMPLEMENTATION POINTS

The mandate of the mental health lead would include the following tasks:

- establish and maintain regularly scheduled contact with emergency responders in the aftermath of the incident;
- coordinate and convene cross-agency debriefings;
- take steps to ensure a continuum of care to responders in the immediate, short and long term;
- advise the leadership of public safety agencies on issues that affect personnel mental health (including work and shift assignments);
- liaise with the post-incident support lead (Recommendation C.12) to coordinate the provision of service to emergency responders whose needs cannot be met through public safety agencies;
- advise the provincial government concerning unmet needs; and
- evaluate the impact of the mass casualty on emergency responders and provide advice to public safety agencies, other employers, and the provincial government concerning steps to be taken to better meet wellness needs.

Post–critical incident wellness plans should include:

- **provision for relief workers** to relieve emergency responders affected by the critical incident;
- **changes to leave policies** to facilitate emergency responders taking the time required to meet their wellness needs;
- the opportunity to jointly **debrief** after a critical incident;
- provision for **more in-person meetings and communication** in the post-incident period;
- **sufficiency of support resources**, both regularly and over a longer period of time;
- **uniformity in support resources** for emergency responders (including civilians) across agencies;
- **facilitation of on-site support** for responders;
- **coordination of supports** within public safety agencies to facilitate access by emergency responders;
- resources for **in-house wellness units** following a mass casualty to meet the additional demands; and
- training for **coach officers / supervisors / managers / leaders** to ensure proactive support of emergency responders with up-to-date information about available mental health supports and understanding of the issues facing emergency responders members on the ground.

Chapter 8: Meeting the Support Needs of Affected Persons and Communities

MAIN FINDING Nova Scotia Health Authority Mental Health and Addictions Program and Nova Scotia Victim Services took steps to meet the immediate needs of affected persons and communities through a range of initiatives undertaken in partnership with IWK Health Centre and other partners. These services did not fully meet the support needs following the April 2020 mass casualty.

The extent of unmet need cannot be measured because a needs assessment has not been carried out nor has there been an evaluation of the support services provided to date.

MAIN FINDING Factors that limited the effectiveness of support services include the lack of knowledge about support needs, lack of community awareness about and accessibility of services, rural healthcare scarcity and scarcity of mental health services, a misalignment of needs and services provided, failure to provide spaces for the sharing of experiences among affected community members, insufficient attention to grief and trauma, lack of coordination between service providers, and lack of continuity in services.

MAIN FINDING COVID-19 and the work of the Mass Casualty Commission were compounding factors that affected the need for and access to support services.

LESSON LEARNED The Nova Scotia and Canadian healthcare systems do not adequately integrate mental health care within the organization and delivery of healthcare services. These systemic inadequacies contributed to the inability of the Nova Scotia Health Authority to adequately respond to the mental health needs of those affected by the mass casualty.

Members of Nova Scotia rural communities experience chronic limitations on access to health and social services. These limitations compounded the problems in access that many residents have experienced, and continue to experience, in the aftermath of the mass casualty.

Recommendation C.10

MAINSTREAMING AND INCREASING AVAILABILITY OF MENTAL HEALTH SERVICES

The Commission recommends that

Federal, provincial, and territorial governments should develop a national action plan to promote better integration of preventive and supportive mental health care into the Canadian healthcare system, so as to ensure greater access to these services on an equal level as physical healthcare.

LESSON LEARNED Many Nova Scotians and other Canadians have not been provided with the resources needed to foster grief, bereavement, trauma, and resiliency literacy. This lack hinders the ability of individuals and families to develop healthy coping strategies following a mass casualty, including through seeking formal and informal support and assistance.

Recommendation C.11

ENHANCE GRIEF, BEREAVEMENT, TRAUMA, AND RESILIENCY LITERACY

The Commission recommends that

(a) The Nova Scotia Health Authority, in consultation with community-based health organizations and service providers in the affected communities, should develop a public education and awareness campaign to foster greater literacy about grief, bereavement, trauma, and resiliency.

(b) Other Canadian health authorities, in consultation with community-based health organizations and service providers, should take steps to increase grief, bereavement, trauma, and resiliency literacy.

IMPLEMENTATION POINT

- These education and awareness campaigns should include ongoing education in schools. Consideration should also be given to include them alongside existing programs – for example, as a requirement for workplaces as part of workers compensation programs.

LESSONS LEARNED Mass casualties give rise to extensive individual and community needs for a range of health and social service supports that require existing systems to scale up their capacity on an urgent basis.

Preplanning and preparedness is required to enable an effective community-centred response for the provision of support services to affected individuals and communities in the immediate, short, medium, and long term.

Post-critical incident support plans and protocols should be developed during the preparation phase and liaisons should be established to ensure a smooth transition to this plan as soon as practicable following a critical incident.

Like all aspects of community-centred critical incident response, the support service plan requires community engagement and relationship building during the preparedness phase.

Plans ensure a rapid and sustained response that includes the capacity to assess need from the perspective of those affected; effective systems for ensuring awareness about and accessibility of services; and the capacity to scale up support services by making additional resources available to meet immediate, short-, medium-, and long-term needs.

Recommendation C.12

POST-MASS CASUALTY INCIDENT SUPPORT PLANS

The Commission recommends that

(a) Health Canada, in consultation with provincial and territorial health authorities and subject matter experts, should develop a national policy, protocols, and program to provide a range of health and social support services required by those most affected by a mass casualty, both for individuals and for communities as a whole.

(b) The national policy and protocols should establish a national standard that can be adapted to the specific circumstances of the mass casualty, and the program should include allocations of funding to support their implementation.

(c) The national standard for post-mass casualty incident support plans should be developed on the basis of, and integrate, these guiding principles:

  (i) respectful treatment of those most affected, including through recognition of their unique perspective, experiences, and needs and their involvement in the implementation of the post–critical incident support plan;

(ii) recovery and resilience established as the desired outcomes;

(iii) trauma-informed and victim-centred service provision;

(iv) proactive, comprehensive, and coordinated support services that include navigation assistance;

(v) commitment to providing services in the immediate, short and medium, and long term; and

(vi) ongoing needs assessments, monitoring, and periodic evaluation of programs and services.

(d) One of the national protocols should provide that a multidisciplinary team be established and mobilized within 24 hours to assist local service providers to initiate a support plan immediately following a mass casualty.

(e) The protocols for post-mass casualty incident support plans should provide for the designation of a post-incident support lead with the responsibility to coordinate the implementation of the plan, including through adapting it to the specific circumstance of the mass casualty.

(f) The national program should liaise with the National Resource Hub for Mass Casualty Responses (Recommendation C.2) to develop and operationalize a knowledge exchange network to facilitate the sharing of promising practices, research, and evaluations across Canada, including through monitoring international developments in post-critical incident support planning and service provision.

IMPLEMENTATION POINTS

- Service providers should receive training to enable theme to provide support services following a mass casualty, including through modules to support the wellness of service providers who are engaged in this work.
- The national policy and protocols should include the issue of the financial assistance required to support affected persons and communities.
- The national policy and protocols should include designated liaisons for directly affected family members who live elsewhere in Canada, beyond the jurisdiction of the mass casualty, or outside Canada.
- Trauma-informed training should be integrated across public sector service delivery and be made available to community-based organizations.

Chapter 9: "We Will Write Our Own Story"

LESSONS LEARNED The Province of Nova Scotia has not fully met the needs of the communities most affected by the April 2020 mass casualty, resulting in a health deficit and public health emergency.

The long-term impact of unresolved complicated grief and traumatic loss can be devastating to individuals and is counter to the community deep-seated need to build a positive community legacy.

Recommendation C.13

REVERSING THE COURSE: ADDRESSING THE PUBLIC HEALTH EMERGENCY IN COLCHESTER, CUMBERLAND, AND HANTS COUNTIES

The Commission recommends that

(a) By May 1, 2023, the Governments of Canada and Nova Scotia should jointly fund a program to address the public health emergency that exists in Colchester, Cumberland, and Hants counties as a result of an unmet need for mental health, grief, and bereavement supports arising from the April 2020 mass casualty.

(b) This program should be developed and implemented by a local multidisciplinary team of health professionals with the ability to draw on external resources as needed.

(c) The program should provide concerted supports on an urgent basis and transition to long term care over time.

(d) Mi'kmaw communities should have the opportunity to participate in the program either on a joint or an independent basis.

(e) The program should be funded to carry out needs and impact assessments in 2023, 2025, and 2028.

IMPLEMENTATION POINTS

- The program should consult with members of marginalized groups living in the most affected communities to determine how to best meet these needs.
- The plan should include assessing and meeting the needs of women at Nova Institution for Women who have been affected by the mass casualty.
- Organized and supported peer-to-peer networks should be developed as one element of this plan,
- To the extent that sufficient resources are available, consideration should be given to the provision of services in other parts of the province.

PART C: COMMUNITY-ENGAGED SAFETY AND WELL-BEING

Chapter 10: From Community-Based Policing to Community Safety and Well-being

LESSONS LEARNED Early iterations of community-based policing models failed to live up to their promise because of a range of institutional, cultural, and societal factors.

This early model was based on a flawed concept of what constitutes police community relations and a flawed premise that police-led directives and initiatives alone could be the basis of a shared understanding of the requirements for community safety.

Community-based policing failed to become entrenched in policing culture.

The concept of community policing needs to be transformed and replaced by a focus on community safety and well-being recognizing the primary role of other institutions and agencies, including community-based organizations.

The community, not the police, needs to be at the centre of a modernized community safety and well-being model, with the police serving as a collaborative partner, not as the primary actor in this social system.

The economics of policing requires a broader discussion through the lens of the economics of community safety and well-being.

Chapter 11: Facilitating Community Engagement

Recommendation C.14

ENACTING COMMUNITY SAFETY AND WELL-BEING LAWS

The Commission recommends that

(a) The federal government should enact legislation within six months to create a statutory framework designed to support and enhance community safety and well-being in every province and territory. This national framework would be based on guiding principles central to the delivery of public services that include:

  (i) the centrality of a commitment to equality and inclusion as foundational principles for community safety and well-being;

  (ii) a prevention-first approach to safety;

  (iii) an understanding that social determinants of health are also the social determinants of community safety and well-being;

  (iv) an understanding that police and corrections are layers of this approach to community safety and well-being as decentred and collaborative partners;

  (v) community-informed municipal / provincial/territorial multi-sectoral processes to ensure more efficient collaboration between different agents of community safety and well-being;

(vi) an essential focus on community engagement, including input from and consultation with historically overpoliced communities, in any legislative initiative focused on community safety and well-being; and

(vii) the sharing of personal information between public sectors (including police, education, health, social services, and corrections) when necessary to achieve the success of these community safety and well-being initiatives, while respecting the privacy rights of an individual.

(b) Where they have not already done so, provincial and territorial governments should each enact laws within a year to create a statutory framework for community safety and well-being initiatives. These frameworks should include provision for:

(i) the establishment within a year of a Community Safety and Well-Being Leadership Council composed of leaders from all sectors, including non-police sector partners (e.g., leadership from health and community-based organizations, gender-based violence advocacy and support sector, historically marginalized communities). This council would be parallel to the federal counterpart and include liaison or joint members.

(ii) municipalities (individually or jointly) to prepare and adopt community safety and well-being plans in partnership with a multi-sectoral advisory committee;

(iii) community safety planning to address four areas: social development, prevention, early intervention, and incident response;

(iv) engagement, collaboration, and communication between the community, groups, agencies, and service providers;

(v) community engagement, beginning with the development of comprehensive community safety needs assessments, followed by information sharing, awareness raising, and involvement in specific actions and strategies under the plan;

(vi) the sharing of personal information between public sectors (including police, education, health, social services, and corrections) when necessary to achieve the success of these community safety and well-being initiatives, while respecting the privacy rights of an individual; and

(vii) each community, province, and territory, in alignment with the fundamentals of a national framework, to fashion localized frameworks to best meet the unique needs and circumstances of their communities.

(c) Federal, provincial, and territorial governments should ensure these laws are supported by adequate long-term public funding that puts crime prevention on an equal footing with enforcement of the criminal law.

Recommendation C.15

COMMUNITY SAFETY AND WELL-BEING LEADERSHIP COUNCIL

The Commission recommends that

To further strengthen federal, provincial, and territorial initiatives that may already be underway, we recommend that the federal legislation include the establishment within a year of a Community Safety and Well-Being Leadership Council composed of leaders from all sectors, including non-police sector partners (such as health and community-based organizations, gender-based violence advocacy and support sector, and historically marginalized communities). This council should not be driven by any one organization but should facilitate shared responsibility for addressing social issues. It should

(a) formulate strategies for addressing social issues together; and

(b) lead a multi-sectoral approach that centres prevention by collaboratively addressing the social determinants of community safety and well-being.

Recommendation C.16

COMMUNITY SAFETY AND WELL-BEING FUNDING ALLOCATION

The Commission recommends that

Federal, provincial, and territorial governments should

(a) adopt funding allocation methods for community safety and well-being initiatives that take into account rural and remote contexts, and

(b) shift budgets to focus on prevention activities.

IMPLEMENTATION POINTS

These laws should

- recognize gender-based, intimate partner, and family violence as a central inhibitor of community safety and well-being;
- prioritize safety and well-being in marginalized communities, recognizing the past and ongoing collective trauma resulting from systemic racism, colonialism, and other processes of marginalization and oppression; and
- ensure that rural communities have an active role in planning for safety and well-being in their communities.

The laws should be accompanied by public and institutional education on community safety and well-being to ensure that there is an understanding of the correlation between properly funding initiatives for prevention and increased overall community safety This public and institutional education should explain that current funding is being applied in fragmented ways in different government departments and agencies but would be more efficiently used if coordinated under an overall approach. It should reinforce the concept of the economics of community safety and well-being, that is, that the responsibility and economic weight for public safety does not rest solely at the feet of, or in the hands of, the police. Community Safety and Well-Being Leadership Councils should

- assist municipalities, provinces, and territories to build and sustain local multi-sectoral approaches at the service delivery level through the establishment of partnerships among multi-agency teams; and

- support information-sharing and coordination across sectors through mechanisms such as regular meetings, frequent informal communication, co-location of services, and cross-agency secondments.

Monitoring and evaluation mechanisms should be adopted with a defined timeline for implementation:

- Community safety and well-being initiatives should be evidence-based and best-practice informed.
- The design of community safety and well-being plans should include provision for longitudinal studies, data sharing among all partners, as well as metrics to assess the impact and outcomes and processes for monitoring and evaluation, and to identify the most promising actions and strategies.
- A national strategy is needed to support research-based community action and to build community capacity.

All governments should adopt the main features of the recommendations for public service reform made by the Scottish Commission on the Future Delivery of Public Services (chaired by Dr. Campbell Christie):

> **People**: Reforms must aim to empower individuals and communities by involving them in the design and delivery of the services.
>
> **Partnership**: Public service providers must work more closely in partnership, integrating service provision to improve their outcomes.
>
> **Prevention**: Expenditure must be prioritised on public services which prevent negative outcomes.
>
> **Performance**: The public services system – public, non-profit and private sectors – must reduce duplication and share services to become more efficient.*

* Scottish Government, Commission on the Future Delivery of Public Services, Dr. Campbell Christie, Chair (June 2011).

Chapter 12: Rethinking Roles and Responsibilities

LESSONS LEARNED Bystander intervention is an effective means to prevent gender-based, intimate partner, and family violence, and individuals of all ages should understand how to safely employ this strategy when they learn about or witness these situations.

Cultural, social, individual, and situational factors act as barriers to effective bystander intervention.

Recommendation C.17

PROMOTING BYSTANDER INTERVENTION AS A DAILY PRACTICE

The Commission recommends that

(a) The federal government should:

  (i) renew and extend bystander intervention awareness and education campaigns and support their implementation in a wide range of settings, including in education, in workplaces, and in the provision of public services; and

  (ii) develop and implement a longitudinal evaluation of these campaigns.

(b) Provincial and territorial governments should develop and implement a mandatory gender-based violence and bystander intervention training curriculum in the school system commencing in kindergarten and continuing until Grade 12.

(c) Municipal, provincial, territorial, and Indigenous governments should develop and implement gender-based, intimate partner, and family violence bystander intervention training for their workplaces and staff.

(d) Colleges, universities, and other education and training institutions and workplaces, to the extent they are not already doing so, should provide practical training in support of effective and safe bystander intervention.

IMPLEMENTATION POINTS

- These campaigns and programs should be designed to effectively counteract cultural barriers to bystander intervention.
- These campaigns and programs should be designed to effectively prevent violence in the moment and address social and cultural factors that contribute to condoning gender-based violence.
- These campaigns, programs, and evaluations should be developed and implemented in collaboration with the gender-based violence advisory and service sector.
- These campaigns, programs, and evaluations should be developed and implemented in collaboration through community engagement processes, particularly with members of marginalized communities and with rural communities.

LESSONS LEARNED Businesses have important roles and responsibilities as part of a whole of society response to gender-based, intimate partner, and domestic violence.

These responsibilities include ensuring that workplaces are safe and promote well-being, supporting employees who are dealing with violence outside of the workplace, being an active part of the community safety ecosystem, and contributing more generally to the promotion of gender equality and inclusion.

Recommendation C.18

BUSINESSES AND INDUSTRY ASSOCIATIONS CHAMPIONING ENDING GENDER-BASED VIOLENCE

The Commission recommends that

Businesses should:

(a) undertake a self-assessment of how effectively their existing policies, programs, culture, leadership, and strategy are tackling violence and harassment and supporting survivors and bystanders and whistleblowers;

(b) undertake a self-assessment of how effectively their existing policies, programs, culture, leadership, and strategies are addressing violence and harassment committed by their employees;

(c) commit to a leadership role in fostering cultural shifts that challenge the normalization of gender-based violence and integrate this shift into their business practices; and

(d) play an active role in the development and implementation of community safety and well-being plans.

LESSONS LEARNED Traditionally, professional licensing bodies regulate their licensees through an individual complaints-based system that is insufficiently proactive.

Community safety and well-being can be promoted through more proactive monitoring of licensees.

Members of marginalized communities are particularly at risk of being subjected to poor treatment and unethical or illegal behaviour.

Recommendation C.19

PROACTIVE MONITORING BY PROFESSIONAL LICENSING BODIES

The Commission recommends that

All professional licensing bodies should:

(a) monitor their members proactively to better ensure the safety and well-being of their licensees' clients / patients;

(b) through careful monitoring, track and proactively demand accountability when discernible patterns of unethical or illegal behaviour are uncovered; and

(c) take steps to promote awareness of complaints mechanisms, including by requiring that licensees prominently display the *Code of Ethics* and information about the complaints process in their offices / clinics and online.

IMPLEMENTATION POINTS

- Practice audits and quality control systems can assist in proactive monitoring.
- Professional licensing bodies should:
  - acknowledge that marginalized communities face barriers to reporting concerning behaviour; and
  - take steps to minimize these barriers through engagement with these communities.

Recommendation C.20

OVERSIGHT OF PUBLICLY FUNDED SERVICES TO POOR AND MARGINALIZED COMMUNITIES

The Commission recommends that

All levels of government should monitor the provision of public health services by independent service providers to people of lower economic means (and those who are otherwise marginalized) to ensure that quality services are being delivered in compliance with professional standards, including ethical codes.

Governments should work in partnership with professional regulatory bodies for this purpose.

PART D: APPLYING LESSONS LEARNED: ACCESS TO FIREARMS AND COMMUNITY SAFETY

Chapter 13: Access to Firearms and Community Safety

LESSON LEARNED Priority should be placed on reducing access to the most dangerous, high-capacity firearms and ammunition in recognition of the risks they pose and the fact they do not serve a hunting or sporting purpose.

Recommendation C.21

REDUCING GUN LETHALITY

The Commission recommends that

(a) The federal government should amend the Criminal Code to prohibit all semi-automatic handguns and all semi-automatic rifles and shotguns that discharge centre-fire ammunition and that are designed to accept detachable magazines with capacities of more than five rounds.

(b) The federal government should amend the *Criminal Code* to prohibit the use of a magazine with more that five rounds so as to close the loopholes in the existing law that permit such firearms.

(c) The federal government should amend the *Firearms Act*

  (i) to require a licence to possess ammunition;

  (ii) to require a licence to buy a magazine for a firearm; and

  (iii) to require a licensee to purchase ammunition only for the gun for which they are licensed.

(d) The federal government should establish limits on the stockpiling of ammunition by individual firearms owners.

(e) The federal government should reform the classification system for firearms and develop a standardized schedule and definitions of

prohibited firearms within the *Criminal Code* of Canada, with an emphasis on simplicity and consistency.

(f) The federal government should take steps to rapidly reduce the number of prohibited semi-automatic firearms in circulation in Canada.

LESSON LEARNED The safety of women survivors of intimate partner violence is put at risk by the presence of firearms and ammunition in the household.

Recommendation C.22

REVOCATION OF FIREARMS LICENCES FOR CONVICTION OF GENDER-BASED, INTIMATE PARTNER, OR FAMILY VIOLENCE

The Commission recommends that

(a) The federal government should amend the *Firearms Act* to automatically revoke the firearms licences of persons convicted of domestic violence or hate-related offences.

(b) The federal government should amend the *Firearms Act* to suspend the firearms licences of persons charged with such offences; where such charges are diverted, withdrawn, stayed, or otherwise resolved without trial, the suspension should remain in place and the burden of proof should be on licence holders to demonstrate they are not a risk or a threat to others.

(c) The federal government should consult with Indigenous groups, the gender-based violence advocacy and service sector representatives of rural communities, firearms officers, and police services to create guidance for the consistent, effective, and safe enforcement of these provisions.

IMPLEMENTATION POINT

- We endorse jury recommendation #13 of the Ontario Office of the Chief Coroner's 2022 inquest into the murders of Carol Culleton, Anastasia Kuzyk, and Nathalie Warmerdam (the Renfrew County Inquest). This recommendation would require all police services to immediately inform the chief firearms officer (CFO) of charges related to intimate partner violence after they are laid, and provide any relevant records, including Firearms Interest Police information collected for the police database and used by chief firearms officers to screen applicants for firearms licences.

LESSON LEARNED The current firearms regime does not adequately protect against the unlawful transfer of firearms upon the death of the owner.

Recommendation C.23

PREVENTION OF UNLAWFUL TRANSFERS OF FIREARMS FROM ESTATES

The Commission recommends that

The federal, provincial, and territorial governments should enact legislative and regulatory changes required to prevent unlawful transfers of firearms from estates.

IMPLEMENTATION POINTS

- Create mechanisms to transfer information from government databases such as Vital Statistics to firearms officers, which would ensure that firearms officers receive immediate notification of a death or licence expiry and take action to identify, retrieve, and secure firearms.
- Educate those administering an estate about their responsibility for the timely and legal deactivation, surrender, or destruction of firearms in the estate and hold them accountable.

LESSON LEARNED Effective border control requires a collaborative and coordinated approach among border agencies with interoperable systems for the sharing of records and information.

Recommendation C.24

INTEROPERABILITY OF LAW ENFORCEMENT AGENCIES ENGAGED IN FIREARMS CONTROL AT THE CANADA–UNITED STATES BORDER

The Commission recommends that

(a) All law enforcement agencies with a shared mandate to stop the illegal entry of firearms into Canada should develop fully interoperable systems for the sharing of records and information.

(b) All law enforcement agencies should develop a collaborative framework to ensure effective scrutiny at the border.

(c) Canadian enforcement agencies should engage local border communities to assist in the prevention of illegal cross-border transfer of firearms, and Canada should encourage American law enforcement agencies to do likewise.

LESSONS LEARNED Firearms regulations are not enforced in a consistently effective and accountable manner, leading to gaps and uneven enforcement within and across jurisdictions.

Current approaches are ineffective partially as a result of inadequate community engagement, particularly with the gender-based violence advocacy and support sector and with firearms officers.

Recommendation C.25

EFFECTIVE, CONSISTENT, AND ACCOUNTABLE ENFORCEMENT OF FIREARMS REGULATIONS

The Commission recommends that

(a) The federal government should engage with communities, the gender-based violence advocacy and support sector, and firearms regulatory officers to develop practical guidance policies for the effective, consistent, and accountable enforcement of firearms regulations.

(b) The federal government should engage communities, the gender-based violence advocacy and support sector, and firearms regulatory officers to develop a framework for the collection of data about firearms enforcement.

(c) The federal government should collect, analyze, and report data on enforcement of firearms regulations publicly.

(d) The federal government should immediately ratify and implement the *Inter-American Convention Against the Illicit Manufacturing of and Trafficking in Firearms, Ammunition, Explosives, and Other Related Materials* (CIFTA) and the *Protocol Against the Illicit Manufacturing of and Trafficking in Firearms, Their Parts and Components and Ammunition* (Firearms Protocol).

(e) The federal government should fully implement the *Programme of Action to Prevent, Combat and Eradicate the Illicit Trade in Small Arms and Light Weapons in All Its Aspects* (PoA) and the *International Instrument to Enable States to Identify and Trace, in a Timely and Reliable Manner, Illicit Small Arms and Light Weapons* (also known as the United Nations International Tracing Instrument, or ITI).

IMPLEMENTATION POINTS

- The Ontario Office of the Chief Coroner's 2022 inquest into the murders of Carol Culleton, Anastasia Kuzyk, and Nathalie Warmerdam (the Renfrew County Inquest) made a number of recommendations to improve

enforcement which provide a strong starting point. We endorse that inquest jury's recommendation numbers 69–73.

> The Chief Firearms Officer [CFO] should work with appropriate decision-makers to:
>
> 69. Review the mandate and approach of the CFO's Spousal Support line to:
>
> (a) Change its name to one that better reflects its purpose. It should be clear that it is broadly accessible and not limited to a particular kind of relationship,
>
> (b) Be staffed 24 hours a day and 7 days a week,
>
> (c) Be publicized to enhance public awareness, and become better known among policing partners possibly through All Chiefs' bulletins.
>
> 70. Create guidelines for staff in making decisions regarding whether to issue, review, revoke, or add conditions to PALs [Possession and Acquisition Licences] to ensure consistency among staff and through time. Particular attention should be paid to red flags and risk factors around IPV [intimate partner violence], including where there is no conviction.
>
> 71. Require that a PAL is automatically reviewed when someone is charged with an IPV related offence.
>
> 72. Require PAL applicants and holders to report to the CFO in a timely manner any change in information provided in application and renewal forms submitted to the CFO, including when an individual with weapons restrictions comes to reside in their home.
>
> 73. Amend PAL application and renewal forms to require identification as a surety.

- Steps should be taken to promote standardization and quality control measures in data collection by police, as well as mandatory collecting of information by federal, provincial, and local police,
- This information should be publicly reporting on an annual basis.
- Information gathered could include:

- disaggregated data on firearm death, injury and crime including gender, age, region and other pertinent characteristics;
- types of firearms used (unrestricted, restricted (handguns) and others) and their sources (legal owner, diverted from legal owner, smuggled);
- offender/ victim relationship (was the perpetrator known or unknown to the victim; if the perpetrator was known, what was his or her relationship to the victim);
- firearm ownership and whether the person who used the gun was licensed;
- the number of firearms-related investigations, charges and complaints;
- a breakdown of the data by gender of suspect / victim; offence type; type of firearm; and demographic indicators such as age, educational level and income;
- the steps and outcome of steps undertaken by police in response to a firearm related complaint, including the number of firearms removed from individuals following the expiry of a licence; the suspension of a licence; the revocation of a licence; and the issuance of an order in the criminal courts prohibiting an individual from possessing firearms; and
- the outcome of tracing efforts in each case.

LESSONS LEARNED There is a lack of community knowledge about the Canadian firearms regime. It is influenced by the United States discourse centred on a right to bear arms which does not exist in our constitutional and legal structure.

This discourse has become increasingly polarized and steps should be taken to reverse this trend through enhanced community engagement.

There is a lack of community knowledge about the impact of firearms-related harms. Some community members do not have accessible, safe mechanisms to report concerns over firearms ownership, storage and use. Proactive measures are needed to support compliance.

Recommendation C.26

PUBLIC HEALTH APPROACH TO GUN SAFETY

The Commission recommends that

(a) The federal, provincial, and territorial governments should adopt legislation affirming that gun ownership is a conditional privilege.

(b) The federal government should implement a nation-wide comprehensive public education campaign directed at increasing awareness of existing firearm-related laws and regulations, options for raising complaints and concerns, and the risks associated with firearms in the home, including risk factors associated with accidental injury, suicide, domestic violence, hate crimes, and diversion of lawfully owned guns.

(c) The federal government should establish a national firearms hotline in consultation with communities, the gender-based violence advocacy and support sector, firearms regulations officers, and police services.

(d) The federal government should work with the gender-based violence advocacy and support sector and healthcare professional organizations to develop a framework for the establishment of a duty of care to report concerns about potential violence and firearms.

(e) The federal government should implement measures that support compliance with firearm storage laws, including subsidizing storage facilities in communities where this is a barrier to compliance.

(f) Indigenous governments should implement measures to support compliance with firearm storage laws.

Chapter 14: Police Paraphernalia

LESSONS LEARNED Police impersonation is a serious public safety issue, and this outweighs the interests of collectors to own items of police paraphernalia that can be used as a disguise.

The perpetrator's use of the replica RCMP cruiser and disguise during the April 2020 mass casualty has led to a significant increase in public mistrust of the RCMP and, more generally, the police. Mistrust of police is itself a public safety issue.

As a result of the mass casualty, some people, particularly in the most affected communities, continue to experience fear at the sight of police cars, particularly RCMP cruisers. Some members of marginalized community groups, such as those who have been overpoliced and underprotected by police, also experience fear and anxiety when confronted by police symbols. Policing agencies must work to build trusting and constructive relationships with the communities they serve.

In some cases, police services do not appropriately manage the inventory and disposal of police vehicles and any associated equipment, kit, and clothing, including upon retirement of police officers.

It is difficult to regulate access to many specific items of police paraphernalia. Comprehensive approaches, such as Nova Scotia's *Police Identity Management Act*, are required.

Recommendation C.27

RECORDS OF POLICE IMPERSONATION CASES

The Commission recommends that

The Canadian criminal intelligence database be amended to provide for the sharing and storing of police impersonation cases and that such cases be tracked in the Violent Crime Linkage Analysis System database.

Recommendation C.28

MANAGEMENT AND DISPOSAL OF POLICE UNIFORM AND ASSOCIATED KIT

The Commission recommends that

(a) The RCMP and other police services should review their policies on the management and disposal of police uniform and associated kit to ensure they include proactive and effective measures to manage inventory and disposal including:

  (i) a process for tracking items issued, returned, and destroyed; and

  (ii) a process for verifying environmentally sound disposal.

(b) The RCMP and police services should carry out a quality assurance review of their inventory and disposal systems within one year of the publication of this Report and on a triennial basis thereafter.

(c) The RCMP implement the recommendations made in the July 2022 audit of the RCMP's equipment management processes.

(d) The RCMP and other police services should ensure that when police officers retire or otherwise cease their roles as peace officers, they return all items of police uniform and kit, including ceremonial uniform and badges.

IMPLEMENTATION POINTS

- The practice of issuing veteran or retired member badges should cease immediately.
- Police services may make arrangements to return badges to members in good standing, after encasing them in a block of hard plastic of sufficient size to render the badge unusable.
- Police services should issue officers who retire or otherwise cease their work in good standing, after a minimum period of service, an appropriate veteran's blazer, clearly distinguishable from any police

uniform (ceremonial or general duty) issued to currently working members.

(e) The RCMP should work with the RCMP Veterans Association to ask retired members to return items in their personal possession, including badges that have not been encased in plastic and uniforms.

IMPLEMENTATION POINTS

- Such badges may be encased in a block of hard plastic of sufficient size to render the badge unusable, and returned to the retired member.
- Police agencies should work with their veterans associations to ensure that retired officers in good standing have access to an appropriate veteran's blazer, if they wish to have one.

Recommendation C.29

REGULATING THE PERSONAL POSSESSION OF POLICE PARAPHERNALIA

The Commission recommends that

(a) The Province of Nova Scotia amend the *Police Identity Management Act* to remove the exception for personal possession of ceremonial uniforms.

(b) Other Canadian provinces and territories enact legislation equivalent to the Nova Scotia *Police Identity Management Act*.

Recommendation C.30

SALE OF DECOMMISSIONED VEHICLES

The Commission recommends that

(a) The minister for public safety should retain a moratorium on the sale of decommissioned RCMP vehicles to the public until a third-party review of the decommissioning process has been completed, any recommendations arising from this review have been implemented, and alternative avenues for disposal (such as transfer to other government agencies or other levels of government) have been pursued.

(b) If sales to the public are resumed, the RCMP should publicly report on an annual basis the number of vehicles sold and the net revenue raised by such sales.

IMPLEMENTATION POINTS

- Conscious of the environmental cost of scrapping vehicles that are in good condition, we encourage the minister of public safety and the RCMP to work with GCSurplus to investigate alternative means of retaining roadworthy vehicles within government fleets, even when they are no longer suitable for policing.
- The moratorium on selling RCMP vehicles to the public should be retained at least until a third-party review of the decommissioning process has been completed.

Recommendation C.31

GCSURPLUS TRACKING, TRAINING, AND OVERSIGHT

The Commission recommends that

(a) GCSurplus and any company that performs a similar function of disposing of policing assets should develop and implement a policy to identify, track, and report suspicious activity by buyers and potential buyers.

(b) GCSurplus and any company that performs a similar function of disposing of policing assets should train its warehouse employees to identify suspicious behaviours and follow this policy and provide management oversight of this role.

Chapter 15: Cultivating Healthy Masculinities

LESSON LEARNED Promoting healthier masculinities is an important strategy for improving community safety and well-being in two ways: preventing gender-based violence, and improving male health and well-being.

Recommendation C.32

PROMOTING AND SUPPORTING HEALTHY MASCULINITIES

The Commission recommends that

(a) The federal government should develop and implement a national public health education and awareness campaign to promote healthy masculinities.

(b) As part of the National Action Plan to End Gender-Based Violence, the federal government should support research, evaluation and knowledge exchange about promising practices to support healthy masculinities through primary prevention, strategies to intervene in and respond to

the perpetration of gender-based violence, and to efforts to promote the recovery and healing of male perpetrators.

(c) All Community Safety and Well-Being Leadership Councils (see Recommendation C.15) should integrate initiatives to promote and support healthy masculinities in primary prevention strategies, in strategies to intervene in and respond to the perpetration of gender-based violence, and in efforts to promote the recovery and healing of male perpetrators.

IMPLEMENTATION POINTS

- All strategies designed to promote and support healthy masculinities should centre diverse and intersecting identities, including Indigenous cultures and identities and should take anti-racist, anti-colonization, and anti-oppressive approaches.
- Following their appointment, the Gender-Based Violence Commissioner should be engaged in developing the federal initiatives (Recommendation V.17).

Volume 5: Policing

PART A: THE CRITICAL INCIDENT RESPONSE

Chapter 1: Five Principles of Effective Critical Incident Response

LESSON LEARNED Five strong and consistent principles for effective critical incident response emerge from the literature on critical incident preparedness and best practices. When these principles are not followed, critical incident responses suffer. Ineffective critical incident responses can result in more casualties and cause damage to community trust in police and other emergency services.

Recommendation P.1

PRINCIPLES OF EFFECTIVE CRITICAL INCIDENT RESPONSE

The Commission recommends that

All Canadian police agencies should implement five principles of effective critical incident response:

1. Prepare for critical incidents before they happen, first by acknowledging that they can arise, by training personnel, and by establishing clear roles and responsibilities for critical incident response.
2. Recognize that every critical incident is unique, and therefore that training and preparation must equip first responders, communications (911) operators, supervisors, and commanders to make decisions and act in conditions of considerable uncertainty.
3. Ensure that planning, policies, and training include other agencies that will be involved in a critical incident response, fostering a culture of interoperability among emergency responders.

4. Recognize that affected community members are the "true first responders" to a critical incident, and that they will play a crucial role in any critical incident response including by providing information to police and communications operators. Police agencies should engage in clear, timely, and accurate public communications, including information that will help community members to protect themselves and others, during a critical incident.
5. Evaluate every critical incident response after it takes place, whether the response went well or not. Identify lessons learned, areas for improvement, and practices that should be emulated. All personnel who are involved in a critical incident response should be included in a post-incident evaluation. In turn, these lessons should be shared in purposeful and coordinated ways to ensure institutional and public learning.

Chapter 2 Critical Incident Command and Decision-Making

MAIN FINDING Contrary to national RCMP policy, in April 2020 the Bible Hill RCMP detachment had no emergency operational plan in place, and, similarly, H Division had no violent crime-in-progress emergency operational plan. The 2011 *Emergency Operations Plan: Violent Crime in Progress* did not reflect current policies or training and was not in use at the time.

MAIN FINDING H Division had implemented the MacNeil Report recommendation to establish an emergency operational plan that identified major transport routes and critical locations to stop or contain an active threat from moving across the province. However, those in command of the critical incident response of April 18 and 19, 2020, were unaware of the existence of this plan, and it was not used during the mass casualty.

Recommendation P.2

EMERGENCY OPERATIONAL PLANS

The Commission recommends that

The RCMP should ensure emergency operational plans are current and utilized throughout all divisions.

MAIN FINDING Acting Cpl. Stuart Beselt was not the scene commander. Rather, he acted in accordance with RCMP policy by moving toward an active threat as the leader of an IARD response.

LESSON LEARNED Police agencies should have clear rules about the consumption of alcohol and recreational drugs while police officers are on duty. Given the nature of police work, the appropriate standard is to have no alcohol or recreational drugs in one's system when on duty.

Recommendation P.3

CONSUMPTION OF ALCOHOL AND RECREATIONAL DRUGS

The Commission recommends that

The RCMP should amend its *Code of Conduct* to state clearly that members must have no alcohol or recreational drugs in their system while on duty, and that they must not report for duty or self-deploy if they have consumed alcohol or recreational drugs.

MAIN FINDING We conclude that S/Sgt. Brian Rehill acted as ad hoc critical incident commander until S/Sgt. Jeff West assumed control at 1:19 am on April 19, 2020. However, we find that there was confusion about the command structure and about who among the RCMP members were performing specific roles and responsibilities in this interim period. We also find that this confusion detrimentally affected the critical incident response, most notably with respect to the lack of an assigned on-scene supervisor to exercise scene command.

LESSON LEARNED It is essential for responding officers to know who has command of a critical incident response. Policies should clearly assign this role, at all stages of the critical incident response. Information about who has command, and other information about supervisory roles and responsibilities, should be shared regularly with responding members during a critical incident response. Other supervisors must refrain from giving directions to responding members.

Recommendation P.4

SUPERVISION DURING A CRITICAL INCIDENT RESPONSE

The Commission recommends that

(a) The RCMP should amend its policy to identify which non-commissioned officer will attend the scene of a critical incident response. This person must attend as soon as possible.

(b) During a critical incident response, the name and rank of the person who holds command and the name and rank of the scene commander should be recorded in the incident log and broadcast frequently by radio.

(c) Supervisors who have not been tasked with commanding the response should refrain from giving direction to responding members.

Recommendation P.5

ROLES AND RESPONSIBILITIES DURING A CRITICAL INCIDENT RESPONSE

The Commission recommends that

RCMP policies should be amended to make roles and responsibilities during a critical incident response clearer. In the period before a critical incident commander assumes command, ad hoc command of the response should be situated with a suitably experienced, properly trained, and appropriately resourced supervisor within the district command structure.

MAIN FINDING Risk managers and district supervisors were not adequately trained and had not practised for a large-scale critical incident response. The lack of standardized training, and the overall inadequacy of supervisor training, contributed to problems within the early critical incident response.

MAIN FINDING Most supervisors involved in the initial critical incident response on April 18, 2020, had not taken the mandatory online Initial Critical Incident Response (ICIR) 100 training. In any event, this training is inadequate to equip front-line supervisors with the skills necessary for a large-scale initial critical incident response.

LESSON LEARNED Front-line supervisors play a critical role throughout a critical incident response, and they must be adequately trained to perform this role effectively.

Recommendation P.6

FRONT-LINE SUPERVISOR TRAINING

The Commission recommends that

The RCMP should commission an external expert review of its initial critical incident response training for front-line supervisors (ICIR 100 and ICIR 200), to be completed within six months of the publication of this Final Report. This evaluation should be published on the RCMP's website.

IMPLEMENTATION POINTS

This review should assess:

- whether existing mandatory training adequately equips front-line supervisors to exercise initial command until an accredited critical incident commander takes command (noting that present RCMP practice means that it may be several hours before a critical incident commander assumes command);
- the rate of compliance with mandatory training requirements among front-line supervisors;

- whether the existing ICIR 200 course adequately equips front-line supervisors to exercise initial command until an accredited critical incident commander takes command;
- the rate of completion of ICIR 200 among front-line supervisors; and
- whether ICIR 200 should be mandatory for front-line supervisors, with or without amendments.

LESSON LEARNED Critical incident commanders must have ready access to all of the equipment they need to perform their role.

Recommendation P.7

BASIC COMMAND EQUIPMENT

The Commission recommends that

Every critical incident commander should have a "ready go duty bag" with them at all times when they are on call. This bag should contain necessary equipment including police radio, RCMP cellphone, laptop with access to RCMP Computerized Integrated Information and Dispatch System and mapping technology, charging cables, critical incident commander guidebook, and checklists.

LESSON LEARNED Critical incident decision-making places unique demands on police and other agencies. Effective critical incident decision-making is a skill that can and should be taught to those who may respond to a critical incident. It is particularly important for those in supervisory positions.

Recommendation P.8

TRAINING FOR CRITICAL INCIDENT DECISION-MAKING

The Commission recommends that

The RCMP and other first-responding agencies should engage with appropriate experts and training institutions to incorporate "grim storytelling" and other skills of critical incident decision-making into basic and advanced training for police and communications operators. This training is especially important for critical incident commanders, risk managers, and front-line supervisors. These skills should be reinforced in critical incident command and emergency management courses and practised regularly.

LESSON LEARNED The highest priority in a complex critical incident response is to ensure that the response reaches the stage, as quickly as possible, where strategic decisions are being made by a fully trained and experienced critical incident commander with the tactical support of properly trained, well-equipped, on-scene, front-line supervisors.

Recommendation P.9

RAPID DEPLOYMENT OF CRITICAL INCIDENT COMMANDER

The Commission recommends that

The RCMP should put policies and standard operating procedures in place to ensure that an accredited critical incident commander with access to all relevant RCMP systems and infrastructure assumes command of a critical incident response as soon as possible after a critical incident begins, even if this means that the command post is physically distant from the critical incident.

IMPLEMENTATION POINTS

- In H Division, critical incident commanders should use the critical incident operations room in Dartmouth headquarters when this facility can be most rapidly stood up as a command post.

- The nearest detachment to the critical incident or another suitable place should be designated and staffed as a local coordination centre. Local commanders of other agencies (e.g., fire chiefs) should be directed to the local coordination centre, and a detachment supervisor should be in place to ensure that integrated command and shared situational awareness are maintained across agencies and locations.
- Moving to a model of remote command places even greater importance on the training and preparedness of front-line supervisors to act as scene commanders and local command. Districts should ensure that supervisors who are located in detachments are fully trained to exercise scene command, establish staging areas, establish a local coordination centre, and liaise effectively with other emergency responders and the remote critical incident commander.
- For a prolonged critical incident response, it may be appropriate for a critical incident commander to establish a local command post. In this circumstance, a second critical incident commander should be dispatched with all necessary equipment and support to that location, while the initial critical incident commander retains command from the remote command post.
- Media and public communication plans must ensure that the safety of media representatives, media liaison officers, and public communications staff is accounted for when local command locations, staging areas, and perimeters are established.
- The Incident Command System and Emergency Operations Centre models, presently used for integrated response to natural disasters and similar emergencies, may provide an appropriate model for this approach.

MAIN FINDING Different members responded in different ways during the response to the active mobile threat presented by the perpetrator. In general, though, the overall emphasis on chasing the perpetrator, rather than coordinating a strategic response to ensure that other necessary tasks were also completed, impeded the effectiveness of the RCMP's critical incident response and, at times, caused additional harm.

Chapter 3 Information Management During the Critical Incident Response

LESSON LEARNED Public safety answering point policies and procedures should ensure that information obtained via 911 calls or from responding members is captured, even if its accuracy or significance cannot be ascertained in the moment. To support this objective, it is important for communications operators and supervisors to have ready access to 911 call recordings to ensure that all relevant information from a 911 call can be captured and conveyed to responding members.

Recommendation P.10

CAPTURING INFORMATION FROM 911 CALLS

The Commission recommends that

All staff at the RCMP Operational Communications Centre and staff at other public safety answering points should have access to 911 call recordings at their desk and be trained in how to play calls back.

IMPLEMENTATION POINT

- Standard operating procedures should encourage call-takers, supervisors, and risk managers to review calls whenever it may assist them to glean more information or review the completeness of the incident activity log.

Recommendation P.11

INCIDENT LOGGING SOFTWARE

The Commission recommends that

The RCMP should review its incident logging software to ensure that it allows call-takers and dispatchers to capture all information, and that standard operating procedures ensure that Operational Communications Centre staff members are able to capture all relevant information, even for complex incidents. These procedures should be scalable so that, during a critical incident, communications operators are following the same procedures they follow for more routine calls.

Recommendation P.12

CALL-TAKER TRAINING AND STANDARD OPERATING PROCEDURES

The Commission recommends that

(a) The RCMP and Nova Scotia Emergency Management Office should review call-taker recruitment and training to ensure that 911 call-takers are trained to capture all information shared by a community member as fully and accurately as possible, and to listen for background noises or information that may also be important for first responders.

(b) RCMP dispatchers should be trained and standard operating procedures should require that information obtained by call-takers be shared using standard language that signifies the source of the information (e.g., caller says she saw the person carrying a gun; call-taker heard possible gunshots in the background of the call). Important information should be shared repeatedly, and updates or conflicting information should routinely be identified.

LESSON LEARNED 911 call-takers play an important role in our community safety ecosystem. They not only capture and relay information from 911 callers for first responders, but also play a crucial role in helping community members to stay safe.

Recommendation P.13

RESPONSIBILITIES TO 911 CALLERS

The Commission recommends that

(a) The RCMP Operational Communications Centre training and procedures should be amended to emphasize the ethic of care for 911 callers and the central role played by 911 call-takers in eliciting important information from callers and helping community members to stay safe and share information even when they are injured or terrified.

(b) The RCMP instruction to call-takers, issued after the April 2020 mass casualty, to end the conversation with callers who can't see a perpetrator during a critical incident response should be reversed in favour of a policy that gives equal weight to strategies for obtaining relevant information about all aspects of a critical incident including, for example, the location of injured community members and advising callers about steps that will help keep them safe.

MAIN FINDING By 10:30 pm on April 18, 2020, the RCMP had received information from numerous sources that the perpetrator was driving a replica RCMP cruiser that, to most observers, would be indistinguishable from a real RCMP vehicle. This information should have shaped the command decisions from that time forward.

The failure to recognize that the perpetrator had disguised himself in this way was a product of deficiencies in the RCMP's process for capturing, sharing, and analyzing information received during a critical incident response.

LESSON LEARNED Member tracking technology, and proper training in the use of that technology, improves both the effectiveness of a large-scale critical incident response and public and member safety during the response.

MAIN FINDING Despite Ret'd. A/Commr. Alphonse MacNeil's warnings about the importance of being able to track member locations during a critical incident, the RCMP failed to implement the recommendation with respect to geo-tracking Emergency Response Team members in a timely manner. In this regard, RCMP leadership failed its front-line members and the public, both of whom would have been better served in April 2020 if the RCMP had then implemented a recommendation made in the December 2014 MacNeil Report.

MAIN FINDING The gap that arose in the RCMP's efforts to contain a perimeter east of Portapique and the command group's failure to recognize that the blueberry field road provided an alternative route out of Portapique for a motorized vehicle were not materially caused by any inadequacies in the RCMP's mapping technology. H Division was inadequately prepared for a large-scale critical incident response in a relatively remote area of Nova Scotia. The uncertainty about roles and responsibilities, and the lack of training and preparedness of front-line supervisors, were the primary reasons for the gaps that arose in containment.

LESSON LEARNED Effective radio use is important at all times, and essential during critical incident response. Police agencies should emphasize the importance of following radio protocols, and should have plans in place for managing radio communications during large-scale incidents.

Recommendation P.14

EFFECTIVE USE OF POLICE RADIOS

The Commission recommends that

(a) The RCMP should

(i) commission and publicly share an international evaluation of best practices in radio transmission and incorporate the results of this evaluation into its training, policies, and practices;

(ii) conduct a holistic review of radio training for members, supervisors, and dispatchers, including the means by which changes in policy, procedure, and equipment are communicated and implemented;

(iii) prepare plans for managing radio communications during large-scale critical incident responses;

(iv) evaluate radio and uniform design to ensure that the Emergency Request to Talk (ERTT) button is accessible when it is needed; and

(v) incorporate radio use and challenges with radio communication into scenario-based and tabletop training.

(b) RCMP leadership, supervisors, and Operational Communications Centres should

(i) emphasize effective radio use and adherence to proper radio protocols at all times to ensure that good practices are routine; and

(ii) conduct an annual assessment of division-wide compliance with training and policy.

IMPLEMENTATION POINTS

- RCMP radio protocol should
  - require that the speaker identify themselves by name, rank, and role if relevant; and
  - identify the intended recipient of the transmission, deliver the message, and await confirmation of receipt by the intended recipient.
- Any upgrades to radio technology should be accompanied by member-wide training and practice.

LESSON LEARNED Police agencies should proactively establish arrangements for air support, including backup plans. Air support providers should be included in critical incident training.

Recommendation P.15

AIR SUPPORT

The Commission recommends that

(a) The RCMP should establish partnerships with other agencies to ensure that air support is available whenever necessary to a critical incident response.

These agencies should be included in future training and preparation for critical incident response to ensure that they are able to provide the support required.

(b) The RCMP should adopt a single air support call-out process, to ensure that initial critical incident commanders do not waste time and attention looking for alternative sources of air support.

LESSON LEARNED During a critical incident response, many agencies work together to address the threat and restore safety. It is essential that these agencies have a clear and shared understanding of their respective roles and responsibilities, that they have practised together, and that they can communicate effectively with one another.

Recommendation P.16

INTEROPERABILITY DURING CRITICAL INCIDENT RESPONSE

The Commission recommends that

(a) Clear protocols for unified command posts and agency roles and responsibilities should be established among all agencies involved in critical incident response.

(b) All emergency response agencies in Nova Scotia should be given access to encrypted radios while responding to a critical incident, even if these radios are loaned for the duration of that response. Emergency responders must be given the opportunity to train with these radios on a regular basis so that they are familiar with their use, when needed.

(c) Interagency scenario-based and tabletop exercises should be incorporated into existing agency training wherever possible. If this is not possible, agencies should regularly make time for dedicated interagency training.

Chapter 4 Public Safety During Critical Incidents

MAIN FINDING The tweet sent at 11:32 pm on April 18, 2020, was the only information shared publicly by the RCMP until 8:02 am on April 19, 2020. To the extent that the 11:32 pm tweet underplayed the seriousness of the threat to the public, the RCMP had ample opportunity to correct the public record. It took far too long to do so.

LESSON LEARNED Effective public communication during critical incidents requires clear policies, planning, and training. When police do not communicate effectively, community members may be unaware of an active threat to their safety and/or unsure about how to stay safe.

Recommendation P.17

PUBLIC COMMUNICATION DURING CRITICAL INCIDENTS

The Commission recommends that

(a) The RCMP should amend its policies, procedures, and training to reflect the approach recommended in the 2014 MacNeil Report about the RCMP's response to the Moncton Mass Casualty; that is, that the RCMP should activate public communications staff as part of the critical incident package.

IMPLEMENTATION POINTS

- The responsibility to prioritize and engage public communications staff must be clearly allocated.
- A public communications officer should be embedded within the command post.
- Effective implementation of this recommendation requires far more than an email to RCMP employees.

(b) The RCMP should train critical incident commanders and front-line supervisors in their responsibilities to provide timely and accurate public communications about a critical incident. This responsibility should be stated within RCMP policies and procedures.

(c) The RCMP should fully integrate public communications into its approach to critical incident response, including training and tabletop scenarios, and communications officers should train and practise alongside other members of the command group.

IMPLEMENTATION POINTS

- Procedures for approving the timing and content of public communications should be set out in standard operating procedures and regularly practised.
- Strategic communications units should extend their template communications database to address a wider range of content and potential scenarios. This database should be continually updated on the basis of new incidents and insights from training and practice.

(d) Consistent with their legal duty to warn the public, police agencies should disseminate public information using methods that ensure that public communications reach those who are most affected by an incident in a timely manner. When choosing communications strategies, police agencies should attend to matters of equity and substantive equality, including demographic differences in the use of social media platforms, as well as the accessibility of reliable internet and cell service.

IMPLEMENTATION POINTS

- Effective public communications may require different strategies in different circumstances, or for different sectors of the community.
- When a public communication is issued about a critical incident or similar event, the strategic communications unit should conduct a post-incident review of the timeliness, accuracy, reach, and effectiveness of the public communication.

MAIN FINDING On April 18 and 19, 2020, key RCMP personnel, including the command group and risk managers, did not consider the option for an emergency broadcast to be sent via the Alert Ready system until the Nova Scotia Emergency Management Office contacted the RCMP directly. This failure to consider issuing an emergency broadcast reflects a systemic failure on the part of RCMP H Division,

over several years, to recognize the utility of Alert Ready for its emergency public communications. This systemic failure persisted despite individual efforts to draw the attention of H Division's leaders to the opportunities afforded by Alert Ready.

MAIN FINDING The widespread beliefs that community members will panic and that they cannot be trusted to respond appropriately to information about threats to their safety are myths. These myths persist despite abundant evidence to the contrary. These myths have no legitimate place in police decision-making about whether to issue a public warning about an active threat to community safety.

Recommendation P.18

ISSUING PUBLIC WARNINGS

The Commission recommends that

(a) When an active threat to the public exists, police agencies should share the best available information about the nature of the threat and how to remain safe with the public as soon as possible. Police agencies should be prepared to correct or update information as necessary.

(b) Police and emergency services agencies should tailor the means by which public warnings are issued to the location, scale, and duration of a threat. Police and emergency services agencies should ensure that public warnings reach as many community members within an at-risk population as possible.

Recommendation P.19

TRAINING PERSONNEL TO ISSUE PUBLIC WARNINGS

The Commission recommends that

The training police agencies give to critical incident commanders and risk managers should emphasize the duty to issue public warnings and equip these personnel with tools to identify when a public warning is necessary and to decide how best to issue that warning.

Recommendation P.20

ADDRESSING MYTHS AND STEREOTYPES ABOUT COMMUNITY RESPONSES TO PUBLIC WARNINGS

The Commission recommends that

The RCMP and the Canadian Police College should incorporate material that identifies and counters the operation of myths and stereotypes about community responses to critical incidents into immediate action rapid deployment training, initial critical incident response training, and Canadian Police College training for critical incident commanders.

Recommendation P.21

NON-URGENT PUBLIC INFORMATION LINE

The Commission recommends that

The Nova Scotia Emergency Management Office should work with Nova Scotia police agencies to establish a phone line and website that can be used by community members to report non-urgent information during a critical incident and to obtain further information about how to respond to a public warning. Information about this facility should become a standard inclusion in public warnings about critical incidents.

Recommendation P.22

PUBLIC EDUCATION ABOUT PUBLIC WARNINGS

The Commission recommends that

The Nova Scotia Emergency Management Office and Nova Scotia police agencies should engage in a public education campaign, including in schools, to increase public awareness about public warnings and public understanding of how to respond to these warnings.

PART B: THE CONTINUING CRISIS

Chapter 5 Post-Event Learning

LESSON LEARNED Operational debriefs and after-action reports provide an invaluable means of capturing lessons learned from a critical incident response. It is important to include all responding members in these processes.

Recommendation P.23

OPERATIONAL DEBRIEF AND AFTER-ACTION REPORT

The Commission recommends that

The RCMP should implement policies and procedures to require an operational debrief and after-action report for any critical incident response that required the active engagement of a critical incident commander.

IMPLEMENTATION POINTS

The policies and procedures should include the following:

- The commanding officer of the division will direct in writing that the operational debrief process is engaged and assign a commissioned officer to oversee the completion of an operational debriefing and to prepare an after-action report.
- A supervisor who possesses the skills and training to conduct operational debriefings will be assigned to facilitate these sessions, and the debriefing will include all employees who played a part in a critical incident response.
- A written summary of the operational debrief must be submitted by the assigned supervisor of the operational debrief to the commissioned officer who has been appointed to oversee this process and produce the after-action report.
- A comprehensive after-action report should be produced by the assigned commissioned officer. This after-action report should highlight any risk areas for immediate action.

- The after-action report should be submitted to the commanding officer within 30 days of the event occurring. In the event that the 30-day timeline is not met, approval in writing is required by the commanding officer with a stated due date.
- The commanding officer should address any risk areas identified in the after-action report for immediate action, including any updates to relevant policy, procedures, and training, as soon as practicable. Reporting on implementation of these items should be a standing item on monthly bilateral meetings so that progress can be monitored and roadblocks addressed.
- The after-action report and a written response from the commanding officer should be shared within 60 days of the critical incident with every employee who participated in the critical incident response, with the RCMP Operational Readiness and Response Unit, and with the deputy commissioner of contract and Indigenous policing for their situational awareness and institutional review.
- Where the commanding officer or deputy commissioner of contract and Indigenous policing identifies the need for an after-action review, that review should be commissioned within 90 days of the critical incident. A copy of the after-action report and written summary of the operational debriefing should be shared with the independent reviewer.

Recommendation P.24

PUBLIC REPORTING ON CRITICAL INCIDENT RESPONSE

The Commission recommends that

The RCMP should prepare and publish an annual report that explains what the RCMP has learned from operational debriefings and what changes it has made in response to after-action reports in the previous year. This report should provide an amount of tactical and operational information similar to that provided by other agencies; for example, ALERRT (Advanced Law Enforcement Rapid Response Training) Center reports and (US) National Policing Institute reports such as the Orlando Pulse nightclub report.

Recommendation P.25

AFTER-ACTION REVIEW OF MASS CASUALTY INCIDENTS

The Commission recommends that

Within 90 days of a mass casualty incident occurring, the RCMP should initiate an after-action review to be conducted by an arm's length reviewer.

IMPLEMENTATION POINTS

- This review should be commissioned by the deputy commissioner of contract and Indigenous policing and should supplement, not replace, the process set out for operational debriefings and after-action reports.
- The after-action review should be completed and published within six months of being commissioned. If this deadline cannot be met, the RCMP should provide a detailed public rationale.
- After-action reviews should provide a similar amount of tactical and operational information to that provided by agencies in other jurisdictions; for example, in ALERRT (Advanced Law Enforcement Rapid Response Training) Center reports and (US) National Policing Institute reports such as the Orlando Pulse nightclub report.

Chapter 6 RCMP Public Communications and Internal Relations After the Mass Casualty

MAIN FINDING RCMP communications personnel and leaders did not have effective standard operating procedures or policy to guide them in their public communications or to delineate the respective roles of national headquarters and divisional personnel after the mass casualty.

LESSON LEARNED Police agencies have an obligation to provide timely, accurate, and candid information about their work to the public.

Recommendation P.26

PUBLIC COMMUNICATIONS AFTER A CRITICAL INCIDENT

The Commission recommends that

(a) The RCMP's national communications policies should be revised to state clearly that the objective of the RCMP's public communications is to provide accurate information about the RCMP's operations, and in particular to respond to media questions in a timely and complete manner. This principle should be limited only by legal restrictions (e.g., privacy laws) and the minimum withholding necessary to protect the integrity of ongoing investigations.

IMPLEMENTATION POINTS

- RCMP employees should work toward the goal of sharing as much information as possible and as quickly as possible.
- Where information is withheld to protect the integrity of an ongoing investigation, that information must be publicly shared as soon as investigative needs no longer apply.
- Where inaccurate information is provided, a public correction must be issued as soon as the error is identified.

(b) RCMP policy and guidance should be amended to require personnel in national headquarters to assist divisional personnel with the operational and communications demands that arise after a complex critical incident or an emergency of similar scale.

IMPLEMENTATION POINTS

- When an incident has had a significant impact on divisional personnel or goes beyond the normal operations of the division, standard operating procedures should provide for additional resources to be assigned immediately to permit accurate and timely information to be conveyed to the public and to support internal briefing.

- National headquarters staff should respect pre-established reporting structures when seeking information from and issuing directions to divisional staff.

(c) The draft "RCMP Crisis Communications Reference Guide and Standard Operating Procedures" should be revised to reflect the findings and recommendations of this Report and it should be reviewed annually thereafter. This document should form the basis for mandatory training for RCMP communications personnel and officers who perform a public-facing role as spokesperson or liaison officer. These personnel should be required to review the guide regularly, and their performance should be evaluated in part by their demonstrated compliance with policy and with the principles set out in the guide.

Chapter 7 Issues Management and Interagency Conflict in the Post-Crisis Period

MAIN FINDING There were several barriers to an effective interagency review of gaps in information sharing and co-ordination in relation to the 2011 Criminal Intelligence Service NS bulletin about the perpetrator. One of those barriers is that the RCMP's Issues Management Team assigned to address the bulletin was not focused on examining it with a view to institutional learning, and there was no other team within the RCMP carrying out that work. A second barrier was the interagency conflict and distrust that prevented involved police agencies from working co-operatively to examine lessons learned arising from the bulletin. A third was the position taken by the RCMP that the bulletin should not be proactively disclosed to the public, which further elevated the mistrust of municipal police leaders.

The RCMP's failure to grapple with the implications of the 2011 Criminal Intelligence Service NS bulletin represented another missed opportunity to learn the lessons that emerged from the mass casualty. The RCMP's decision not to proactively disclose information about the bulletin was not taken for investigative reasons, and this decision increased public and peer mistrust of the organization. The collective failure of Nova Scotia police leaders, including H Division officers, to constructively address the conflict that arose among them in the aftermath of the mass casualty only exacerbated these concerns.

LESSON LEARNED An incident such as a mass casualty should prompt good faith collaboration by police agencies to examine whether gaps in interagency information sharing or coordination affected prior police responses to the perpetrator.

Chapter 8 Involvement of the Serious Incident Response Team in the Post-Crisis Period

MAIN FINDING In the particular circumstances of the investigation at the Enfield Big Stop, in which specialized forensic investigation services were available from the RCMP and from Halifax Regional Police, the Serious Incident Response Team should have taken immediate steps to ascertain which police agency's members were involved in shooting the perpetrator, and engaged the forensic identification services of the other agency.

LESSON LEARNED The Serious Incident Response Team performs a crucial role in safeguarding public trust in the police and the overall fairness of the Nova Scotia criminal justice system. It is imperative that their work be – and be seen by the public to be – independent of the police agencies whose members they investigate.

Recommendation P.27

SERIOUS INCIDENT RESPONSE TEAM INVESTIGATORS AND SPECIALIZED SERVICES

The Commission recommends that

Whenever feasible, the Serious Incident Response Team (SiRT) should perform its work using investigators and specialized services from an agency separate from the one that employs the officer who is the subject of the investigation. If this is not feasible, the decision to use investigators or specialized services from the police agency that employs the subject officer should be made by the SiRT's civilian director. In writing, and at the time when the decision is made, the SiRT director should document the reasons why using resources from the agency that employs the subject officer is necessary.

LESSON LEARNED The Serious Incident Response Team should maintain control over crime scenes and evidence that pertains to its investigations. When a police agency requires access to a crime scene or evidence controlled by the SiRT, that access should be managed by the SiRT.

Recommendation P.28

SERIOUS INCIDENT RESPONSE TEAM CONTROL OF CRIME SCENES AND EVIDENCE

The Commission recommends that

(a) The *Police Act* and *Serious Incident Response Team Regulations* be amended to clarify that

  (i) the SiRT has exclusive control over investigations of serious incidents involving police; and

  (ii) when the SiRT assumes responsibility for an investigation, the SiRT will immediately assume command of all activities related to the scene, exhibits, investigation, and direction of resources.

(b) Where a police agency, including the RCMP, requires access to a crime scene or exhibit in order to pursue a parallel criminal investigation, that access should be managed in accordance with protocols set by the SiRT.

(c) RCMP *H Division Operational Manual* Chapter 54.1 should be amended to reflect the *Police Act* and *Serious Incident Response Team Regulations*, including the above principles.

MAIN FINDING After the Onslow fire hall shooting, the RCMP failed to adhere to its policies and the *Serious Incident Response Team Regulations* with respect to the procedures that must be followed after a serious incident that attracts SiRT jurisdiction.

LESSON LEARNED It is important for police officers and their supervisors to know what to do when a serious incident that may attract Serious Incident Response

Team jurisdiction occurs, and it is important that the *Serious Incident Response Team Regulations* be observed.

Recommendation P.29

KNOWING WHAT TO DO WHEN SERIOUS INCIDENT RESPONSE TEAM JURISDICTION ARISES

The Commission recommends that

(a) RCMP members in supervisory positions should know what steps they must take when a member discharges a firearm or is otherwise involved in a serious incident that attracts Serious Incident Response Team jurisdiction. This includes knowing:

  (i) who is responsible for reporting a serious incident;

  (ii) how to make such a report;

  (iii) the timeline on which such a report must be made;

  (iv) what information the reporting officer must obtain and provide to SiRT about the incident; and

  (v) to separate involved members (both witnesses and subject members) immediately after a serious incident occurs.

(b) Any failure to follow these procedures should be documented in writing by the RCMP, and a copy of that document should be provided to the SiRT.

(c) The RCMP should ensure that H Division members receive training in applicable legislation, RCMP policy, and their obligations and rights with regard to SiRT investigations. This instruction should be incorporated into annual use of force / incident response requalification training.

(d) Supervisory training courses and annual use of force / incident response curriculum should include instruction on legislation, RCMP policy, members' obligations and rights, and requirements of supervisors with regard to SiRT investigations.

LESSON LEARNED Individuals who are affected by serious incidents involving the police are entitled to receive updates about a SiRT investigation and may require victim support services.

Recommendation P.30

PROVIDING SUPPORT TO SERIOUS INCIDENT RESPONSE TEAM WITNESSES

The Commission recommends that

The Serious Incident Response Team establish or revise its procedures to ensure that witnesses and other individuals affected by serious incidents involving the police are provided with updates about the progress of the SiRT investigation and are referred to available support services.

MAIN FINDING The minimum content provided in section 9 of the *Serious Incident Response Team Regulations* for public reports issued by the SiRT is inadequate to discharge the public accountability function performed by the SiRT. Staffing and budget constrain the SiRT's capacity to provide more detailed public reports than it presently supplies.

LESSON LEARNED Communications between the Serious Incident Response Team and the police agency that employs an officer who is subject to a SiRT investigation should be kept to a minimum, and should only be carried out by a designated liaison within the subject police agency. An officer who is the subject of a SiRT investigation should not communicate directly with the SiRT investigator (outside of providing evidence or information to the SiRT) during ongoing investigations.

Recommendation P.31

RCMP LIAISON WITH THE SERIOUS INCIDENT RESPONSE TEAM

The Commission recommends that

(a) RCMP H Division policy should be amended to provide that all RCMP communications and coordination with the Serious Incident Response Team regarding an ongoing investigation must occur through a designated RCMP liaison, who must be a commissioned officer and trained in the responsibilities and expectations of this role. The SiRT should also implement a corresponding policy requiring its investigators not to communicate about ongoing SiRT investigations with members of the subject police agency besides that agency's designated liaison person.

(b) The only purpose for which any other RCMP member may communicate directly with SiRT about an ongoing investigation is when giving a statement or witness interview, which must be coordinated through the RCMP Liaison Officer.

MAIN FINDING Representatives of the Serious Incident Response Team and the RCMP met with one another to exchange information before the SiRT had issued its decision in the Onslow fire hall shooting referral. Their decision to meet reflects a misunderstanding on the part of both the SiRT and the RCMP about their respective obligations to protect the SiRT's independence as a law enforcement and public accountability body.

MAIN FINDING Evidence raising concerns about the reliability of the expert use of force report commissioned by the SiRT in this instance raises questions about the effectiveness of the SiRT's approach to identifying, retaining, and instructing experts and the role of such experts in its decision-making process.

Recommendation P.32

SERIOUS INCIDENT RESPONSE TEAM PROTOCOL FOR INFORMATION EXCHANGE WITH POLICE AGENCIES

The Commission recommends that

(a) The Serious Incident Response Team should adopt a protocol that it will not meet with members of the police agency that employs a subject officer to exchange information about an ongoing investigation.

(b) The SiRT should also adopt a protocol that sets out how information will be exchanged when two agencies are engaged in parallel criminal investigations. Any such exchange of information must occur in writing.

(c) While a SiRT investigation is ongoing, the SiRT should not share information with the agency that employs the subject police officer(s) for the purposes of an internal investigation conducted by that agency, including internal conduct or workplace investigations.

LESSON LEARNED It is important that the Serious Incident Response Team retain experts who are independent and able to provide an expert opinion that will meet Canadian legal standards for expert witnesses.

Recommendation P.33

EXPERT WITNESS RETAINED BY THE SERIOUS INCIDENT RESPONSE TEAM

The Commission recommends that

The Serious Incident Response Team should adopt written protocols for the identification and retention of experts in its investigations. These protocols should reflect Canadian legal principles with respect to the reliability and independence of expert witnesses.

MAIN FINDING Concerns about the impact of an investigation on interagency relationships must never be a basis on which the Serious Incident Response Team declines to exercise its law enforcement powers.

LESSON LEARNED Agencies that investigate alleged criminal wrongdoing by police officers provide a critical law enforcement and public accountability function. They must be adequately resourced and trained to allow them to do their work thoroughly and effectively.

Recommendation P.34

SERIOUS INCIDENT RESPONSE TEAM RESOURCES

The Commission recommends that

The Province of Nova Scotia should undertake a review of the Serious Incident Response Team's budget and staffing complement to ensure it can fully exercise its investigative responsibilities and perform its public accountability function and maximize its contribution to enhanced confidence in policing in Nova Scotia.

Recommendation P.35

SERIOUS INCIDENT RESPONSE TEAM REPORTS

The Commission recommends that

(a) Section 9 of the *SiRT Regulations* should be amended to adopt the language set out in section 34 of the Ontario *Special Investigations Unit Act.* This amendment will ensure that the SiRT's public reports in instances where no charges are laid provide sufficient information to allow the public to understand why SiRT has reached its conclusion and to evaluate that outcome.

(b) Starting immediately, all SiRT reports in which criminal charges are not laid against the subject police officer should be drafted with sufficient detail and analytical transparency to allow the public to understand and evaluate the director's reasoning and conclusions.

PART C: REIMAGINING POLICING IN CANADA

Chapter 9 What Are the Police For?

LESSON LEARNED Police agencies should be democratically accountable, attuned to good evidence about effective practice, and oriented to articulating and serving the common good. They should combine law enforcement with collaborative work to prevent harm and promote and maintain community safety. They should listen to the demands of all citizens, while directing resources toward meeting the needs of the most marginalized members of our communities. They should be subject to strong forms of government and citizen oversight and accountability.

Recommendation P.36

PRINCIPLES OF POLICING

The Commission recommends that

All levels of government and Canadian police agencies adopt the following principles of policing, as framed by Dr. Ian Loader, "In Search of Civic Policing: Recasting the 'Peelian' Principles" (2016):

1. The basic mission of the police is to improve public safety and well-being by promoting measures to prevent crime, harm and disorder.
2. The police must undertake their basic mission with the approval of, and in collaboration with, the public and other agencies.
3. The police must seek to carry out their tasks in ways that contribute to social cohesion and solidarity.
4. The police must treat all those with whom they come into contact with fairness and respect.
5. The police must be answerable to law and democratically responsive to the people they serve.

6. The police must be organized to achieve the optimal balance between effectiveness, cost-efficiency, accountability and responsiveness.
7. All police work should be informed by the best available evidence.
8. Policing is undertaken by multiple providers, but it should remain a public good.

These principles should govern how police do their work and how they are accountable for the work they do.

Chapter 10 A Future for the RCMP

LESSON LEARNED Police agencies and police officers must be capable of acknowledging and taking responsibility for their mistakes.

Recommendation P.37

TAKING RESPONSIBILITY

The Commission recommends that

(a) The RCMP adopt a policy of admitting its mistakes, accepting responsibility for them, and ensuring that accountability mechanisms are in place for addressing its errors. This policy should apply at every level of the institution.

(b) The demonstrated capacity to accept responsibility for one's errors should be a criterion for any promotion within the RCMP.

LESSON LEARNED The minister responsible for the RCMP serves an important democratic accountability function. The minister can and should issue written directions to the RCMP about policy matters, including the policy of operations. It is also necessary for the minister and the commissioner to exchange information,

including information about specific investigations or police operations, to allow the minister to discharge their democratic role. However, the minister must not direct the RCMP about how it pursues particular investigations. Both the minister and the RCMP should be publicly accountable for the ways in which they discharge their responsibilities.

Recommendation P.38

MINISTERIAL DIRECTIONS TO THE RCMP COMMISSIONER

The Commission recommends that

(a) Federal Parliament should amend section 5(1) of the *RCMP Act* to provide:

> The Governor in Council may appoint an officer, to be known as the Commissioner of the Royal Canadian Mounted Police, to hold office during pleasure, who, **subject to this Act and any written directions of the Minister, is responsible for** the control and administration of the Force.

(b) The *RCMP Act* be further amended to include the following provisions:

> (a) The Minister must cause a copy of any such written direction given to the Commissioner to be:
>
> > (i) published in the *Canada Gazette* within eight days of the date of the direction; and
> >
> > (ii) laid before the Senate and the House of Commons within six sitting days of the direction if Parliament is then in session, or, if not, within six sitting days after the commencement of the next session of Parliament.
>
> (b) No Ministerial direction may be given to the Commissioner in relation to the appointment, transfer, remuneration, discipline, or termination of a particular person.

Recommendation P.39

POLICIES GOVERNING THE ROLES AND RESPONSIBILITIES OF THE RCMP AND MINISTER OF PUBLIC SAFETY

The Commission recommends that

(a) The RCMP and the minister of public safety should adopt complementary written policies that set out their respective roles, responsibilities, and mutual expectations in police / government relations. These policies should adopt the principles and findings on police / government relations outlined in Chapter 10 of Volume 5, Policing, of this Report, including specific provisions on the following issues:

  (i) police operational responsibilities;

  (ii) government policy responsibilities;

  (iii) policy of operations; and

  (iv) information exchanges between the RCMP and the government.

(b) These policies should be posted on the RCMP and the Public Safety Canada websites.

Recommendation P.40

PROTECTING POLICE OPERATIONS

The Commission recommends that

The RCMP should establish policies and procedures to protect incident commanders, investigators, and front-line members from exposure to direct government intervention or advice.

LESSON LEARNED The work of the Management Advisory Board for the RCMP should adhere to the principles of transparency and democratic accountability that otherwise apply to the police.

Recommendation P.41

ADVICE OF THE MANAGEMENT ADVISORY BOARD

The Commission recommends that

(a) Federal Parliament should amend Section 45.18(3) of the *RCMP Act* to provide that:

The Management Advisory Board must provide the Minister with a copy or a summary of any advice, information, or report that it provides to the Commissioner, within eight days of providing that advice.

(b) Federal Parliament should add a new subsection, 45.18(4), to the *RCMP Act* to provide that:

The Minister must cause a copy of any document provided by the Management Advisory Board pursuant to section 45.18(3) to be:

(a) published on the website of Public Safety Canada; and

(b) laid before the Senate and the House of Commons within six sitting days of the direction if Parliament is then in session, or, if not, within six sitting days after the commencement of the next session of Parliament.

LESSON LEARNED Conducting investigations into public complaints against police officers is a specialized skill. Police agencies should ensure that such investigations are conducted by personnel who are properly trained in conducting such investigations and who do not have a real or perceived conflict of interest.

Recommendation P.42

INTERNAL INVESTIGATION OF PUBLIC COMPLAINTS

The Commission recommends that

(a) The RCMP allocate sufficient resources to the RCMP Professional Responsibility Unit to ensure that it has the capacity to conduct investigations into public complaints.

(b) The RCMP should not assign public complaints to the direct supervisor of a member who is the subject of a public complaint or to investigators within the same program as a subject member.

Recommendation P.43

CIVILIAN REVIEW AND COMPLAINTS COMMISSION PROCESS

The Commission recommends that

(a) Federal Parliament amend the *RCMP Act* to specify:

  (i) timelines for the RCMP commissioner to conduct an initial investigation and attempt to resolve public complaints, and to respond to CRCC interim reports; and

  (ii) a requirement for the RCMP to publicly report annually on the implementation of CRCC recommendations.

(b) The federal minister for public safety issue a written direction to the commissioner of the RCMP to prioritize the timely investigation of public complaints at the initial stage of the CRCC process and to work to resolve these complaints where possible at the initial stage.

LESSON LEARNED Agencies that investigate public complaints against police agencies must be adequately funded to perform their work fully and effectively. Failure to provide adequate funding risks impairing the independence of these agencies.

Recommendation P.44

CIVILIAN REVIEW AND COMPLAINTS COMMISSION FUNDING AND POWERS

The Commission recommends that

(a) The Government of Canada should ensure that the Civilian Review and Complaints Commission has sufficient stable funding to fulfill its mandate. In particular, in addition to reviewing public complaints, it must be able to conduct systemic investigations and public interest investigations as it deems necessary, and to explore alternative complaint resolution mechanisms, such as Indigenous legal approaches to dispute resolution.

(b) The minister for public safety issue a written direction to the RCMP commissioner that RCMP employees should support efforts by the Civilian Review and Complaints Commission to explore alternative complaint resolution mechanisms.

LESSON LEARNED Provincial and municipal officials have authority to ensure greater community involvement in RCMP decisions about staffing.

Recommendation P.45

COMMUNITY INVOLVEMENT IN SENIOR RECRUITMENT

The Commission recommends that

(a) Provincial ministers and municipal chief administrative officers should discharge their responsibility under the Provincial Police Services

Agreement and the Municipal Police Services Agreement to ensure that they and the community are consulted on the selection of detachment commanders.

(b) The RCMP should facilitate this consultation by ensuring that the provincial minister or the municipal chief officer (as applicable) receives timely notice of a pending change in detachment commander.

LESSON LEARNED Past inquiries and reviews have documented problems in the structure of RCMP contract policing, particularly regarding clarity in the respective roles and responsibilities of contract partners, national RCMP headquarters and RCMP contract divisions. Past recommendations have not been fully implemented, and problems identified in past processes persist today.

Recommendation P.46

IMPLEMENTING THE 2007 BROWN TASK FORCE RECOMMENDATIONS

The Commission recommends that

The RCMP implement the following recommendations that were made by the Brown Task Force in 2007:

Recommendation 41 – Delegation of Decision Making with Respect to Contract Policing The RCMP should examine and review its approval authorities to ensure that those closest to operational police activity have the requisite authority to make decisions in a timely manner.

Recommendation 42 – Contract Partner Participation Headquarters should give greater weight to the views and priorities of contracting authorities and should involve them in a more meaningful way in decisions that have an impact on their jurisdictions.

Recommendation 44 – Roles and Responsibilities of Headquarters The RCMP should develop a written mandate defining the roles and responsibilities of headquarters and its relationship with its divisions.

LESSON LEARNED Longstanding issues with soft vacancies and challenges with recruitment mean that contracting provinces and territories do not receive the active service of the number of RCMP members for which they have contracted.

Recommendation P.47

ADDRESSING CONCERNS ABOUT POSITION VACANCIES

The Commission recommends that

The RCMP should adopt a system that ensures that contracting provinces and territories receive the active service of the number of members for which they have contracted. The RCMP should ensure that temporary vacancies are filled to ensure that appropriate coverage is provided in contract jurisdictions.

LESSON LEARNED Front-line supervisors play a vital role in policing. It is important that front-line supervisors be available to provide field supervision to general duty members and to provide scene command when needed.

Recommendation P.48

ENSURING ADEQUATE FIELD SUPERVISION

The Commission recommends that

The RCMP should ensure that general duty members in rural areas have adequate field supervision and that trained supervisors are available to provide scene command when needed. In smaller districts or detachments, this supervision may be achieved through an on-call rotation for corporals and sergeants. Risk managers, who provide remote supervision, do not fulfill this requirement.

LESSON LEARNED Past inquiries and reviews have called for a comprehensive review of the RCMP. These recommendations have not been implemented.

Recommendation P.49

A COMPREHENSIVE EXTERNAL REVIEW OF THE RCMP

The Commission recommends that

The federal minister of public safety commission the in-depth, external, and independent review of the RCMP recommended by Mr. Bastarache in his 2020 report *Broken Dreams, Broken Lives*. In addition to examining the matters raised by Mr. Bastarache, this review should specifically examine the RCMP's approach to contract policing and work with contract partners, and also its approach to community relations.

Recommendation P.50

RESTRUCTURING THE RCMP

The Commission recommends that

After obtaining the external review recommended here, Public Safety Canada and the federal minister of public safety establish clear priorities for the RCMP, retaining the tasks that are suitable to a federal policing agency, and identifying what responsibilities are better reassigned to other agencies (including, potentially to new policing agencies). This may entail a reconfiguration of policing in Canada and a new approach to federal financial support for provincial and municipal policing services.

MAIN FINDING There is a long history of efforts to reform the RCMP's contract policing services model to be more responsive to the needs of contracting partners and the communities they represent. These efforts have largely failed to resolve long-standing criticisms of the extent to which the RCMP attends to the particular needs and priorities of contract partners or addresses their expressed concerns.

LESSON LEARNED Policies and procedures provide essential guidance to police about how to do their work. They should be clear, concise, and easily used. Police policies should be public and readily available to the public, as a principle of democratic accountability and to help the public know what they can expect when dealing with police.

Recommendation P.51

REWRITE AND PUBLISH RCMP POLICIES

The Commission recommends that

(a) The RCMP should adopt a systematic approach to policies, procedures, plans, and other guidance materials for its Contract and Indigenous Policing business line:

  (i) Existing policies should be rewritten to provide concise, evidence-based, meaningful guidance to RCMP members and employees about core functions.

  (ii) Policies and other guidance documents should reflect – and refer to – Canadian legal principles that guide the exercise of police powers. Gaps and duplication within policies should be eliminated.

  (iii) An institutional process of reviewing policies and guidance documents when training or institutional practice changes should become routine.

(b) The RCMP should post on its public website, as soon as feasible and on an ongoing basis, up-to-date copies of those policies and standard operating procedures that govern the interaction of police with the public, the manner in which policing services are provided to the public, and public communications.

(c) Where a policy or procedure or a portion of a policy or procedure is deemed confidential, the RCMP should post a public description of each exempted section and the reason why it has been deemed confidential.

Recommendation P.52

ROLE OF RCMP CONTRACT PARTNERS AND DIVISIONS IN POLICY

The Commission recommends that

(a) The RCMP should consult contract partners before and throughout the amendment or adoption of policies that affect the delivery of policing services in contract jurisdictions.

(b) RCMP divisions and detachments should be afforded sufficient resources and discretion under policy:

  (i) to consult with contract partners and community representatives about how RCMP policy will be interpreted; and

  (ii) to create operational plans, standard operating procedures, and other guidance documents, in consultation with contract partners, that reflect community resources, local policing objectives, and priorities.

LESSON LEARNED Canadian communities must be able to depend on a timely response to a call for police assistance. While the possibility of immediate response, and the nature of the response, may vary with the geographic context and the nature of the complaint, maintaining the unique responsibilities of police under the rule of law necessitates that adequate police services be provided in rural and remote communities.

Recommendation P.53

ADEQUATE POLICE SERVICES IN RURAL AND REMOTE COMMUNITIES

The Commission recommends that

Where necessary, provincial, territorial, and federal governments must provide financial support to municipalities and local communities including Indigenous

communities for the provision of adequate policing services within rural and remote communities.

LESSON LEARNED Rural policing is challenging work that requires a distinctive skillset. These skills should be recognized, cultivated, and rewarded, and rural police should have access to meaningful career progression opportunities within rural policing.

Recommendation P.54

REVITALIZING RURAL POLICING

The Commission recommends that

(a) The RCMP should establish an attractive career stream for members who wish to develop a specialization in rural or remote policing:

  (i) members should have the opportunity to remain in communities where they are serving effectively and where the community supports their continuation, while progressing within their careers; and

  (ii) potential leaders should also be given the opportunity to pursue further training, including higher education, on matters of particular relevance to rural policing.

(b) The RCMP should ensure that members with current operational experience and expertise in rural and remote communities are represented at all levels of decision-making within RCMP Contract and Indigenous Policing.

Recommendation P.55

COMMUNITY ORIENTATION FOR NEW MEMBERS

The Commission recommends that

(a) Every rural and remote detachment should work with its local community to prepare an orientation program for members who are new to the district.

IMPLEMENTATION POINTS

- All members transferred into a new district or detachment should complete this orientation program within six months of their assignment.
- When possible, this orientation program should include an introduction to other community safety providers such as healthcare providers and women's shelters.
- Whether such meetings are possible or not, new members should receive a package containing details about local service providers, the services they offer, and how they can be contacted when needed.

(b) The RCMP should also establish national standards for the institutional orientation that must be given to any member who transfers between divisions or districts.

IMPLEMENTATION POINTS

These national standards should address:

- completing the local orientation program;
- reviewing policies and standard operating procedures relevant to the member's area of responsibility;
- understanding local command structure, roles, and responsibilities;
- completing training with respect to local or divisional resources (such as radio and communications systems) and local culture and history (such as training programs that relate specifically to local Indigenous or African Nova Scotian communities);

- reviewing applicable legislation and bylaws including, for example, rules relating to matrimonial property on Indigenous reserves; and
- acquiring a knowledge of the local geography – for example, by attending calls and community events across the area served by that detachment.

MAIN FINDING The Depot model of police training is inadequate to prepare RCMP members for the complex demands of contemporary policing, and the RCMP's failure to embrace a research-based approach to program development and police education and its lack of openness to independent research impairs its operational effectiveness.

LESSON LEARNED The existing Canadian standard of police training outside Quebec is inadequate to equip police for the important work they do and for the increasingly complex social, legal and technological environment in which they work. The shortcomings produced by this approach have a disproportionate adverse impact on those who have historically been underserved by police.

Recommendation P.56

MODERNIZING POLICE EDUCATION AND RESEARCH

The Commission recommends that

(a) The RCMP phase out the Depot model of RCMP training by 2032 and the RCMP consult with the Métis and Saskatchewan Federation of Sovereign Indigenous Nations with respect to how the land and the facility should be used in the future.

(b) Public Safety Canada work with provinces and territories to establish a three-year degree-based model of police education for all police services in Canada.

IMPLEMENTATION POINTS

- Implementing police education programs may entail partnering with existing institutions of higher education, and will require collaboration between ministries of higher education and research and federal, provincial, and territorial ministers responsible for policing.
- The new model of police education should be research-based, allow students the opportunity to participate in research, and lead candidates to a three-year bachelor's degree in policing.
- Attention should be paid to ensuring that the new model is accessible and culturally responsive to women, Indigenous students, and other groups that have historically been underrepresented in and underserved by police in Canada. Offering financial support to qualified candidates from these groups may help to attract a more diverse group of policing students. The new police education model should adhere to national standards, but it should be offered on several campuses in different Canadian regions. These campuses will likely be affiliated with existing universities or colleges.
- Ideally, at least one campus should be established in the Atlantic region and one in northern Canada.
- Public Safety Canada should consult with the Finnish Police University College and Finnish Police in the design of this program.

(c) Public Safety Canada and the RCMP should integrate the Canadian Police College into the new police university system subject to the same governance as other institutions in that system.

(d) Responsible ministers and police boards should issue written directions to police services to collaborate with universities on research and programming and in the development of evidence-based policies and procedures.

Recommendation P.57

USE OF FORCE

The Commission recommends that

The Government of Canada and the RCMP should replace the existing use of force provision in the RCMP *Code of Conduct* with the principles set out in sections 2 to 9 of the Finnish *Police Act*.

LESSON LEARNED Conflict management is an essential skill for all police officers, but especially for supervisors and managers.

Recommendation P.58

CONFLICT RESOLUTION SKILLS

The Commission recommends that

(a) The RCMP make in-person conflict resolution training mandatory for all RCMP members before promotion to the rank of staff sergeant or above, and before promotion to an equivalent civilian position.

IMPLEMENTATION POINT

- The RCMP should contract with an external training provider that has an established track record in delivering effective conflict resolution training until such time as a culture of conflict resolution becomes engrained and its internal capacity to deliver effective internal conflict resolution training is established.

(b) The RCMP make demonstrated conflict resolution skills a criterion for promotion to all RCMP leadership positions.

MAIN FINDING Some aspects of the RCMP's management culture impede its operational effectiveness and thwart institutional learning and accountability. Unhealthy patterns include:

- a resistance to acknowledging and taking steps to rectify errors;
- a lack of cultural resources for responding constructively to conflict and criticism;
- an aversion to being responsible for conveying bad news or for making decisions that may be criticized;
- the tendency to make derogatory characterizations of those with whom one experiences conflict; and
- a resistance to acknowledging and grappling sincerely with difficult institutional truths, including the operation of sexism and systemic racism within the RCMP.

LESSON LEARNED Efforts to reform the police can have complex results when they are filtered through the informal norms and values of police organizations. Management culture is an important determinant of the success of efforts at police reform.

Recommendation P.59

RCMP MANAGEMENT CULTURE

The Commission recommends that

(a) Within six months of the publication of this Report, the RCMP commissioner provide to the responsible minister and the Management Advisory Board, and publish on the RCMP website, a document that explains the criteria on which the RCMP presently selects, develops, recognizes, and rewards its commissioned officers and those in equivalent civilian roles. This document should include a detailed explanation of the following:

  (i) how the RCMP will change these criteria to disrupt the unhealthy aspects of the RCMP's management culture; and

(ii) what other steps are being taken to address the unhealthy aspects of the RCMP's management culture that are identified in this Report, in the Bastarache Report, and by the Brown Task Force.

(b) Starting no later than one year after publication of this Report, the Commissioner should provide semi-annual written updates to the responsible minister and the Management Advisory Board on its progress in addressing the recommendations made in this Report. These updates should include timelines for the achievement of each milestone and should also be posted to the RCMP website.

Chapter 11 The Future of Policing in Nova Scotia

LESSON LEARNED Community safety and well-being must be community-specific. Layers of harms caused by colonialism and racism mean that a policing response to endemic issues that arise from those harms in First Nations, Inuit, and Métis communities must be developed through a sincere community engagement process that respects Indigenous laws and provides equitable funding for Indigenous community safety and well-being.

LESSON LEARNED In the absence of comprehensive mental health care services, a significant amount of police time is spent providing crisis mental health responses to Nova Scotians. Police are not well placed to provide these services. Wherever possible, mental health crisis response should be reallocated to trained mental health care providers, and these providers should be adequately funded to perform this role.

Recommendation P.60

PROVIDING MENTAL HEALTH CARE TO NOVA SCOTIANS

The Commission recommends that

(a) The Province of Nova Scotia should establish a comprehensive and adequately funded model of mental health care service provision for urban

and rural Nova Scotians. This model should include first response to those in mental health crisis and continuing community support services to prevent mental health crises from arising or recurring.

(b) The federal government should subsidize the cost of these services at a minimum proportion equal to the proportion to which it subsidizes RCMP policing services.

IMPLEMENTATION POINTS

- We do not make a recommendation about the specific model of mental health care to be adopted, but encourage the provincial government to consult and engage with community stakeholders in choosing the appropriate model, and to make evidence-based decisions that are informed by a diverse representation of community members.
- Regardless of the model chosen, these decisions should prioritize dignity and care within a mental health care framework over a criminal justice response.

(c) A certified mental health specialist should be embedded in the 911 public safety answering point locations across the province and available on call 24/7 to assist with assessing and triaging mental health calls.

IMPLEMENTATION POINTS

- This specialist may both ensure community members are connected with the appropriate non-police allied community safety agency and provide guidance to police responders when they must respond in person.
- This resource is especially important in rural areas where mental health teams may not be an available resource on the ground in a reasonable response time period.
- The comprehensive model should encompass consideration of how 911 standard operating procedures should be updated to reflect that mental health service providers are most often the more appropriate first responders to mental health calls, but that police will be dispatched to these calls when the mental health service provider indicates that this is necessary.

LESSON LEARNED Effective police governance is vital to democratic policing. All participants in police governance, including board members, police leaders, and government officials, should be properly trained and aware of the role and responsibilities of governing boards.

Recommendation P.61

POLICE GOVERNANCE IN NOVA SCOTIA

The Commission recommends that

(a) The provincial Department of Justice design and provide mandatory standard training in police governance.

IMPLEMENTATION POINTS

This training should be mandatory for:

- every municipal police chief, H Division RCMP commanding officer, and detachment commander;
- provincial and municipal civil servants whose work includes the administration of police; and
- police board members and police advisory board members.

This training should:

- address the governance, oversight, and democratic accountability functions of police boards and police advisory boards;
- incorporate the eight principles of policing;
- address findings, lessons learned, and recommendations set out in this report, the Marshall Report, the Ipperwash Report, the Morden Report, the Thunder Bay Police Services Report, the Epstein Report, the Wortley Report, and the Public Order Emergency Commission Report; and
- explain the respective roles and responsibilities of board members, police leaders, and civil servants.

(b) The Nova Scotia Department of Justice should prepare a police board manual and police advisory board manual.

IMPLEMENTATION POINTS

This manual should:

- be published on the Nova Scotia Department of Justice website;
- address the governance, oversight, and democratic accountability functions of police boards and police advisory boards; and
- set out the roles and responsibilities of board members, police leaders, and civil servants.

(c) Municipalities should provide adequate funding to police boards to permit them to conduct independent research, seek legal advice, maintain records, and otherwise discharge their governance role.

(d) Municipalities and the Province of Nova Scotia should ensure that police boards and police advisory boards are fully staffed and performing their governance function.

IMPLEMENTATION POINTS

- All seats on police boards and police advisory boards should be filled through robust recruitment initiatives for qualified and diverse candidates able to make the necessary time commitment;
- municipalities and the province should ensure that boards are meeting at least every three months, in accordance with the *Police Act*; and
- where a board is not meeting, or a board member is not attending meetings, that failure must be addressed in no more than the span of two meetings.

(e) The Province of Nova Scotia should support police boards and police advisory boards to establish an independent website and public contact information to facilitate direct communication with the communities they represent and to facilitate sharing best practices with other police boards.

IMPLEMENTATION POINTS

- This website should host board governance policies, procedures, written directions to chief officers, and records of key decisions taken by the board; and

- where written directions or records of key decisions cannot be made public due to operational relevance or for other reasons, a summary of the nature of the direction must be posted as an interim measure, and the direction or decision itself should be posted if and when the reason for withholding that information lapses.

(f) Police boards and police advisory boards should hold their meetings in a place customarily open to the public. Advance notice of the time, place, agenda, and expected speakers should be posted on the board website.

(g) Police board members and police advisory board members should be proactive in establishing relationships with other community safety providers and with members of communities that have historically been underserved and overpoliced.

(h) Municipalities and the Province of Nova Scotia should ensure that police board members and police advisory board members are fairly compensated for their work if they are not serving as part of another paid role (e.g., as a municipal employee). Lack of compensation is a barrier to the participation of many community members whose voices should be represented in police governance.

Recommendation P.62

PUBLISH POLICE POLICIES

The Commission recommends that

(a) The Nova Scotia Minister of Justice should issue a policing standard that requires police agencies that provide police services in Nova Scotia to publish – online and in an accessible form and location – policies and standard operating procedures that govern the interaction of police with the public, the manner in which policing services are provided to the public, and public communications.

(b) This standard should require that, where a policy or procedure or a portion of a policy or procedure is deemed confidential, the police service must

provide a public description of each exempted section and the reason why it has been deemed confidential.

(c) The federal minister of public safety should issue a written directive to the commissioner of the RCMP, directing compliance with this provincial standard.

LESSON LEARNED Specialized policing services are integral to modern policing. These services should be organized to meet demand throughout the Province of Nova Scotia on an equitable basis.

Recommendation P.63

SPECIALIZED POLICING SERVICES

The Commission recommends that

The Province of Nova Scotia should ensure that specialized policing services are adequate, effective, and efficiently organized to meet the demand throughout Nova Scotia, whether by contract with RCMP or by other means:

(a) Clear and equitable guidelines should be established for how all police agencies may access these specialized services.

(b) These guidelines should also apply to the agency that supplies these services.

(c) Priority of access should be determined by prospective guidelines, not by the identity of the requesting agency or by personal relationships.

(d) A police agency that meets the criteria for access to these services should receive them, and arrangements should be put in place to ensure that disputes between provincial and municipal agencies about cost allocation do not create a barrier to access when needed.

Recommendation P.64

INTEGRATED TEAMS

The Commission recommends that

Police agencies that establish integrated or interoperable teams with other agencies should settle memorandums of understanding, policies, and procedures to govern the operation and management of these teams.

LESSON LEARNED The work performed by public safety answering point employees is highly gendered, extremely stressful, and undervalued in our community safety ecosystem.

Recommendation P.65

STRENGTHENING NOVA SCOTIA 911

The Commission recommends that

The Nova Scotia Emergency Management Office and Public Safety and Security Division of the Nova Scotia Department of Justice should study how best to ensure that recruitment, training, compensation, employee supports, policies, and procedures for public safety answering points are of a quality and standard that appropriately reflects the important role played by 911 call-takers in our community safety and well-being ecosystem.

LESSON LEARNED When conflict among police agencies is allowed to persist, public confidence is undermined and operational effectiveness may be impeded.

Recommendation P.66

ADDRESSING CONFLICT AMONG POLICE AGENCIES IN NOVA SCOTIA

The Commission recommends that

(a) The Province of Nova Scotia should consult with municipal police leaders and RCMP H Division leaders to identify the issues that continue to cause conflict, and to establish a facilitated process for resolving them. Commitments and resolutions made as a result of this process should be documented, and the Province of Nova Scotia should hold police leaders accountable for implementing them.

(b) The Province of Nova Scotia should make in-person conflict resolution training mandatory for all current Nova Scotia chiefs and deputy chiefs and for any candidate who applies to one of these positions.

IMPLEMENTATION POINT

The Province of Nova Scotia should contract with an external provider that has an established track record in delivering effective conflict resolution training, to deliver this training.

(c) The Province of Nova Scotia should establish a dispute resolution mechanism by which an impartial and knowledgeable third party can resolve disputes among policing agencies, or between policing agencies and the Province of Nova Scotia.

(d) The Province of Nova Scotia should establish a policing standard that requires policing agencies to call on one another to provide backup or assistance when appropriate, and that requires those agencies called upon to provide that assistance to the extent of their ability to do so.

LESSON LEARNED Transforming the structure of policing requires the collaborative work of community members, community safety experts, government, and police.

Recommendation P.67

THE FUTURE STRUCTURE OF POLICING IN NOVA SCOTIA

The Commission recommends that

The Province of Nova Scotia should within six months of publication of this Report establish a multisectoral council comprising representatives of municipal police agencies and RCMP, community safety experts, and diverse community representatives to engage with community members and experts and review the structure of policing in Nova Scotia. This council should make recommendations that can be implemented before the 2032 expiration of the Provincial Police Services Agreement.

PART D: EVERYDAY POLICING PRACTICES

Chapter 12 Police Discretion

LESSON LEARNED Perpetrators of violence do not necessarily remain within a single police jurisdiction. Effective information sharing among police agencies is essential to ensure that patterns in perpetrator behaviour can be recognized.

Recommendation P.68

INFORMATION SHARING

The Commission recommends that

(a) Police agencies in Nova Scotia work with the Nova Scotia Department of Justice to establish shared standards for the collection, retention, and sharing of information by police agencies.

(b) Police agencies in Nova Scotia work with the Nova Scotia Department of Justice to establish policies and procedures for raising concerns when a member of one police agency believes that a member of another police agency may not have acted on information that flags a significant risk to community or police safety.

Chapter 13 Five Strategies for Improving Everyday Policing

LESSONS LEARNED Research-based approaches for best practices in police recruitment exist and have been successfully implemented in other jurisdictions.

Recruitment strategies designed to increase the number of police officers from under-represented backgrounds will fail if they are not accompanied by educational and cultural change in Canadian policing.

Recommendation P.69

RECRUITMENT

The Commission recommends that

(a) Canadian police education programs should adopt research-based approaches to student admission processes, based on a clear understanding of the personal characteristics that form the basis for effective democratic policing.

(b) Canadian police agencies should adopt research-based approaches to police recruitment, based on a clear understanding of the personal characteristics that form the basis for effective democratic policing.

(c) Canadian police agencies should establish a comprehensive strategy for recruiting and retaining employees who are presently underrepresented in Canadian policing.

IMPLEMENTATION POINTS

- This strategy should include measures that are designed to support such recruits and allow them to work to the strengths for which they are recruited.
- Police agencies should change established practices and procedures where necessary to establish a safe and welcoming workplace for recruits from historically under-represented backgrounds.

LESSON LEARNED The existing Canadian standard of police training outside Quebec is inadequate to equip police for the important work they do and for the increasingly complex social, legal, and technological environment in which they work. The shortcomings produced by this approach have a disproportionate adverse impact on those who have historically been underserved by police. A three-year police education program in which a research-based curriculum both precedes and undergirds practical training is necessary to equip front-line police officers to exercise legitimate discretion.

Recommendation P.70

CANADIAN POLICE EDUCATION

The Commission recommends that

(a) All Canadian governments and police agencies should, by 2032, adopt a three-year police education degree as the minimum standard for police education.

(b) Police education programs should employ subject matter experts who use research-based approaches to design and deliver curriculum, particularly in areas where police services currently underperform.

(c) Police education programs should offer financial support to Indigenous and racialized students and other students from backgrounds or identities that have historically been under-represented in Canadian police services. Financial means should not be a barrier to obtaining a police education.

MAIN FINDING RCMP policy and everyday practices with respect to member note-taking practices and supervision of member notes are deficient. The national note-taking policy is not adhered to, including with respect to custody of the notebooks, and there is no consistent supervisory practice of monitoring the quality and content of member notes. Further, there is no daily practice of securing the notebooks at detachments.

For this reason, courts, tribunals, and the public need to be aware that simply because something is not reflected in a police officer's notes does not mean it did not happen. Police notes can serve only as a record of what police officers choose to include and how well they capture the information. The notes should not be understood as comprehensive. Courts, tribunals, and the public should exercise caution in drawing inferences from an absence of RCMP members' notes or omissions in notes taken.

LESSONS LEARNED Member notebooks are the primary record of police officers' daily activities and decision-making.

Note taking is a crucial means by which low-visibility decision-making can be supervised and democratic policing principles can be secured. Proper supervision of this basic aspect of policing – note taking – is also an important internal accountability mechanism. Such supervision includes file review and follow up where gaps are identified in note taking and investigation. This supervision is not for punitive reasons; it is to facilitate learning by front-line officers and to ensure that front-line members are addressing the needs of the communities they serve. Regular review also ensures that supervisors gain insights into a member's judgment and can identify areas and act on areas for improvement.

Recommendation P.71

NOTE TAKING

The Commission recommends that

(a) The RCMP, following the recommendation made by the Civilian Review and Complaints Commission, should implement training and supervisory strategies to ensure that all members take complete, accurate, and comprehensive notes.

(b) The RCMP should develop an effective asset management process to retain, identify, store, and retrieve the completed notebooks of its members.

(c) Canadian police agencies should evaluate front-line supervisors' oversight of front-line members' note taking as one criterion by which their performance is assessed.

(d) Canadian police education programs should integrate effective note-taking practices into every aspect of their curriculum – for example, by incorporating note-taking skills and assessment into substantive assignments.

IMPLEMENTATION POINTS

- All Canadian police agencies should adopt the practice of requiring front-line members to provide their notebooks to their supervisor at the end of each shift for review and countersigning.
- Where necessary, electronic alternatives to these supervisory practices (e.g., scanning notebook pages for review and approval by a remotely located supervisor) can be adopted.
- The quality of an agency's note-taking practices should be assessed both by compliance with notebook review policies and by the quality of members' note taking.
- Police notebooks should be stored in police detachments between shifts.

- When members are transferred, resign, or retire, their notebooks should remain at their detachment.
- Canadian police agencies should explore the potential for transitioning to electronic note taking in light of available technologies such as cellphone voice recognition note-taking ability and the increased use of body-worn cameras. Regardless of the platform, the fundamentals of good note taking should be present, including the essential requirement of being able to ensure the integrity of records taken contemporaneously with the events they recount.

MAIN FINDING The RCMP does not have an effective system of front-line supervision in place for general duty members in H Division. This gap deprives general duty members of day-to-day feedback about their performance, including how they exercise discretion.

LESSON LEARNED Front-line supervision and the provision of regular feedback to front-line members are essential components of effective everyday policing practices in order to promote a culture of good judgment, accountability, and taking institutional responsibility for member learning.

Recommendation P.72

SUPERVISION

The Commission recommends that

(a) The RCMP should review the structure of contract policing services delivered in H Division to ensure that every general duty member receives routine and effective supervision, including regular feedback on the quality of low-visibility decision-making.

(b) Shift meetings should become a standard practice at the beginning of every general duty shift in RCMP contract policing. Supervisors should receive training in how to run an effective shift meeting.

IMPLEMENTATION POINT

If the structures we have identified as problematic in H Division also exist in other RCMP divisions, this recommendation should be followed in those divisions too.

LESSONS LEARNED Police decision-making is better when police recognize and draw on the expertise of community leaders and other community safety providers to help them understand their work.

In order to rebuild police legitimacy, police must interact with every community member in a way that indicates they fundamentally respect the people they are serving and behave in ways that will be constructive for relationships between police and community members.

Recommendation P.73

COMMUNITY-ENGAGED POLICING

The Commission recommends that

(a) Police agencies should adopt policies and practices that encourage front-line police to consult with community subject matter experts on questions that will help them better understand and serve their communities. These policies and practices should permit consultation on operational matters.

(b) Community subject matter experts should be paid fairly for their work, and police agencies should establish a budget for this purpose.

Chapter 14 Everyday Policing, Equality, and Safety

LESSON LEARNED Naming and countering the operation of misogyny, racism, homophobia, and other inegalitarian attitudes within policing must be placed at the heart of strategies to improve everyday policing. If police continue to disbelieve women, operate in ignorance about how violence and trauma present, and work in a silo rather than as part of a coordinated community safety system, the problems we have documented in this Report will persist.

Recommendation P.74

COUNTERING SYSTEMIC BIAS

The Commission recommends that

Government, police agencies, and police education programs make the goal of identifying and countering the operation of misogyny, racism, homophobia, and other inegalitarian attitudes central to every strategy for improving the quality of everyday policing in Canada.

LESSONS LEARNED Not every complaint received by police can or should result in charges being laid or a warrant being obtained. However, in every case in which a community member reports violence or a non-frivolous fear of violence to police, the police should consider it their primary responsibility to work with other agencies to prevent escalation of violent behaviours, to investigate, and to protect the safety of those who are at risk.

Recruiting and educating police with an eye to building a culture of respect for equality rights and commitment to countering gender-based violence is an essential part of community-engaged policing.

Documenting patterns of violence through good note taking and supervision, information sharing, and interoperability is critical to assist police and other gender-based violence advocacy and support sector members to identify and act upon red flags in communities.

Recommendation P.75

PREVENTING VIOLENCE AND PROTECTING SAFETY

The Commission recommends that

Government, police agencies, and police education programs emphasize that working with other gender-based violence advocacy and support sector members to prevent an escalation of violence and protect the safety of those who experience violence is the primary purpose of every police response to a complaint of violence or the expressed fear of violence.

Volume 6: Implementation – A Shared Responsibility to Act

Chapter 3 Keystone: Fostering Collaboration and Ensuring Accountability

LESSONS LEARNED No one person or organization has the authority or formal responsibility to implement all of the recommendations made in this Final Report.

Recommendations in some public inquiry reports are not fully implemented because of obstacles to reform and the lack of clear lines of accountability.

Implementation of the recommendations in *Turning the Tide Together* is a responsibility shared among many agencies within the Canadian and Nova Scotian public safety systems and a large group of other actors and agencies, including community groups and members of the public.

Shared responsibility is effective only when it is led by champions; advocated for by stakeholders, communities, and individuals; and supported through mechanisms for monitoring and accountability.

Mutual accountability, clear public reporting, and ongoing public engagement are key to overcoming obstacles and supporting institutional change, cultural shifts, and substantive change over the short, medium, and long term.

Recommendation I.1

TURNING THE TIDE TOGETHER IMPLEMENTATION AND MUTUAL ACCOUNTABILITY BODY

The Commission recommends that

(a) By May 31, 2023, the Governments of Canada and Nova Scotia should establish and fund an Implementation and Mutual Accountability Body with a mandate to

  (i) provide mutual accountability, exchange of knowledge, and support among all organizations and actors involved in the implementation process;

  (ii) consult with community members on priority areas for action and on implementation strategies;

  (iii) establish a monitoring framework and monitor on an ongoing basis, including through the power to request information from federal, Nova Scotian, and municipal public authorities;

  (iv) take active steps to encourage members of the public to participate in the whole of society engagement recommended in this Report;

  (v) provide public information about the process of implementing the recommendations;

  (vi) provide public updates on progress on the implementation plan every three months and publish an annual report on the status of implementation of each recommendation; and

  (vii) liaise with implementation efforts in other provinces and territories.

(b) By May 31, 2023, the Governments of Canada and Nova Scotia should appoint the Founding Chair and Champion of the Implementation and Mutual Accountability Body following consultation with all Commission Participants and representatives of the communities most affected by the April 2020 mass casualty, including the Mi'kmaw communities most affected and representatives of African Nova Scotian communities.

(c) By July 31, 2023, the Founding Chair, in consultation with representatives of organizations with responsibility mandated by this Report's recommendations and other interested individuals and organizations, should present the Governments of Canada and Nova Scotia with a proposed list of members and budget for the Implementation and Mutual Accountability Body.

(d) By September 1, 2023, the Governments of Canada and Nova Scotia should jointly appoint the membership of the Implementation and Mutual Accountability Body.

(e) As soon as practicable, the Implementation and Mutual Accountability Body should develop a plan for monitoring implementation and establish reporting and accountability mechanisms; it should provide the plan to Parliament and the Nova Scotia Legislature, and take other steps to make it available to members of the public, including through the establishment of a dedicated website that tracks updates and progress.

(f) The Implementation and Mutual Accountability Body should provide public updates on progress on the implementation plan every three months and publish an annual report on the status of implementation of each recommendation

IMPLEMENTATION POINTS

Composition: The Implementation and Mutual Accountability Body should include the following members:

- at least two representatives of those most affected by the mass casualty (including families of the deceased and/or survivors);
- a civic representative from one of the affected municipalities;
- a representative of RCMP National Headquarters senior management with authority to act on behalf of the Commissioner;
- the RCMP Deputy Commissioner of Contract and Indigenous Policing
- the Assistant Commissioner of RCMP H Division;
- a representative of the RCMP Management Advisory Board;
- a senior representative of Public Safety Canada;

- a senior representative of Nova Scotia Department of Justice Public Safety;
- at least one community-based representative from the gender-based violence advocacy and support sector;
- at least one representative of Indigenous community organizations engaged in policing reform;
- at least one representative of African Canadian community organizations engaged in policing reform; and
- on their establishment, delegates from the other bodies established under the Report's recommendations:
    - the Federal and Nova Scotia Community Safety and Well-Being Leadership Councils (Recommendation C.17);
    - the Gender-Based Violence Commissioner (Recommendation V.17) or their appointee.

Advisory Group: The Implementation and Mutual Accountability Body should consider establishing an advisory group consisting of other agencies engaged in the Canadian and Nova Scotian public safety systems, policing organizations, the health sector, and victims' advocacy organizations.

Facilitating implementation: The Implementation and Mutual Accountability Body should

- circulate the Commission report and recommendations to stakeholder communities, and communicate and consult with community members on priority areas for action and on implementation strategies; and
- provide the report to the Auditor General of Canada and the Auditor General of Nova Scotia so they might inquire into the progress of implementing these recommendations.

Status reports: Updates should include analysis of information to identify trends, obstacles, delays, problems, issues, and best practices.

Rationale for Non-Implementation: To encourage transparency, where an organization has decided not to implement a recommendation or part of a recommendation, the Implementation and Mutual Accountability Body will request a written explanation of this decision and publish it in reports under the implementation plan.

Volume 7: Process

Chapter 5 Recommendations Related to Future Public Inquiries

Recommendation Pr.1

PRE-INQUIRY PHASE

The Commission recommends that

There should be a consultation phase prior to the establishment of an inquiry. During this phase, governments should identify the commissioner(s) and, pursuant to an appropriate confidentiality undertaking, engage them in discussion about the draft terms of reference in order to ensure the mandate is realistic.* In particular, the scope of the mandate must be achievable in the time frame allotted.

* There is precedent for such discussions. For example, in the Arar Inquiry, Commissioner Dennis O'Connor with his counsel Paul Cavalluzzo negotiated the mandate (see Bessner and Lightstone, *Public Inquiries in Canada: Law and Practice* (Toronto: Thomson Reuters, 2017), 28–29 and 77–78).

Recommendation Pr.2

PREPARATORY PHASE

The Commission recommends that

Following this brief pre-inquiry phase, the Orders in Council should provide for a three-month preparatory phase to allow the commissioners time to

(a) establish appropriate infrastructure such as office space, computers, and phones,

(b) develop a website, and

(c) hire start-up support staff.

Only then should the mandate clock start ticking toward the due date of the final report.

Recommendation Pr.3

EXTERNAL INDEPENDENT AUDIT

The Commission recommends that

An external independent audit of the RCMP and the Attorney General of Canada's document management and production processes be conducted, with the results made public.

Recommendation Pr.4

DESIGNATED DOCUMENT DISCLOSURE BODY

The Commission recommends that

The federal government create a designated body to assist the Attorney General of Canada with document disclosure generally.

Recommendation Pr.5

FORM OF DOCUMENT PRODUCTION

The Commission recommends that

Public inquiries should be authorized to direct the manner in which participants must produce documents in their possession.

Part F:
Next Steps

PART F: NEXT STEPS

Community safety is a shared responsibility and a shared opportunity. We all need to be champions for change, taking the recommendations from this Report and implementing them in our communities, workplaces, organizations, and policies.

Some recommendations can be implemented relatively quickly and easily, while others will take more time and collaboration, both within and between different groups and institutions. In order to build and sustain momentum over the months and years required to make the longer-term changes, people from many different settings and roles across society will need to keep taking action, being advocates, and holding each other accountable in ways that are supportive and constructive.

Implementation and Mutual Accountability Body

Many of the recommendations we make will require action by leaders and teams in government and public institutions such as the RCMP. In the Final Report, we make a number of recommendations to strengthen existing accountability mechanisms or to create new ones. Most important, we are calling for the federal and Nova Scotia governments to jointly form an Implementation and Mutual Accountability Body that will include representatives from government, the RCMP, those most affected, and key community groups. This body will be responsible for creating an implementation plan and providing regular updates to government and to the public.

The Commission was established to serve the public interest. We worked in a transparent fashion and took steps to engage a wide range of people and organizations. As our successor, the Implementation and Mutual Accountability Body should pick up and expand this mantle. We have recommended that this body be established on an urgent basis: its framework, funding, and founding chair in place by May 31, 2023, and the appointment of the members, after consultation with interested individuals and organizations, by September 1, 2023. The Implementation and Mutual Accountability Body should become active that month and issue its first report to the public before the year 2023 ends.

We urge readers to learn more about our recommendation for the Implementation and Mutual Accountability Body in Volume 6, Implementation.

Ways to Stay Engaged for the Broader Community

The Final Report provides a range of recommendations for how to reach our shared goal of making our communities safer. We have made many recommendations that will need to be taken up by political leaders, policy-makers, and the RCMP, along with other public institutions and service providers. As discussed, it is critical that these recommendations are taken seriously and with the required degrees of urgency by the relevant leaders and institutions.

At the end of Volume 6, Implementation, we look beyond public leaders and institutions, focusing instead on the next steps and actions that individuals and groups in our communities can take to make the places we live safer for everyone. These actions may also be relevant to political leaders, first responders, and other institutional representatives acting in their capacity as family members, neighbours, and community members.

We know that the scale of the task ahead can seem overwhelming, and it can be difficult to know where to begin, let alone how to remain engaged and to sustain momentum. We set out here some reflections on the potential strengths and capabilities that different individuals and groups could tap into, based on what we have

observed during the course of our work and what we have learned from other instances of mass violence and harm.

Many people have asked us what they can do. While we have made suggestions for different groups of people, we know there are areas of overlap and that many groups and individuals may have started this work and will have other applicable and effective suggestions. The suggestions include some of the core things we can all do every day that will help to make our communities stronger, such as reaching out to build relationships with each other, checking in and listening to each other regularly, and supporting each other to speak up and seek help whenever it is needed.

Group	Potential Actions
Those most affected	• Stay in contact with each other, providing mutual support based on your shared experiences. • Continue to find ways to commemorate those whose lives were taken, both to honour their memories and so others can learn about what happened and be inspired to act. • Continue to urge your elected representatives at the municipal, provincial, and federal levels to take action based on the recommendations in this Report. You could write letters and request meetings to talk about actions, accountability, and progress. • Form an ongoing advocacy group to coordinate and organize your efforts. Similar groups have been formed by people affected by other mass casualties. For example, family members of the children whose lives were taken during the Sandy Hook Elementary School shooting in 2012 went on to create Sandy Hook Promise. This national non-profit organization promotes gun violence prevention education to youth and adults in the United States. • Join a local community organization or board, sharing your unique experience and perspective. • Continue to seek help if you or someone you know needs it. Reach out to your family, friends, or a dedicated support organization in your community.

Group	Potential Actions
Community organizations and advocacy groups	• Talk about how the findings and recommendations included in this Report are relevant to your community and discuss ways to incorporate them into your ongoing activities. • Inform your community about the factors that can lead to mass casualties, including gender-based, intimate partner, and family violence, and help to create a culture in which it is fine for people who are experiencing violence to speak up and get help. • Build on the networks and coalitions that have been established or strengthened between your group and other organizations. This collaborative approach will make everyone stronger. • Continue to urge your elected representatives and public institutions to pay attention and to take action. • Use this Report, along with the commissioned reports (available in Annex B) and other materials, as a resource to inform your discussions and work. These documents include input from many people, including those who experienced the mass casualty and its related issues and experts who specialize in mass violence, gun control, policing, community resilience, and other relevant issues.
Policy specialists and researchers	• Use this Report, the commissioned reports (available in Annex B), and the many other materials created during the Inquiry as a resource for ongoing discussion, research, and policy development. We heard and learned from many experts, and we encourage you to continue to draw on this wealth of information in your work too. • Consider designing research projects that will help to track the progress that is being made to implement the recommendations in this Report and to address the underlying issues that contribute to mass casualties. This work could contribute to a broadening of accountability, ensuring sustained and shared responses toward building safer communities. • Continue to foster and build networks with your policy and research peers, both here in Canada and around the world. This Inquiry benefited from the input of many academic collaborators, and we believe future collaboration will play an important role in building our shared understanding of common challenges and the progress being made to overcome them.
Members of the public	• Be good neighbours, reaching out to the people in your community and supporting them to find help if they need it. • Be champions for change in your families, communities, and workplaces, speaking up about the issues that contribute to mass casualties and steps we can take to improve community safety. • Volunteer in your community, joining a group or board that is focused on making your community stronger. • Continue to urge your elected representatives and public institutions to pay attention and to take action. • Seek help if you or someone you know needs it. Reach out to your family, friends, or a dedicated support organization in your community.

Group	Potential Actions
Media	Continue to hold public leaders and institutions accountable, reporting on their responses to the recommendations in this Report and their implementation plans, progress, and outcomes. Help inform the public about the broad and systemic issues detailed in this Report that contribute to mass casualties, including gender-based and intimate partner violence. Contribute to building a culture where everyone feels safe to speak up and seek help if they need it.
Businesses	Make sure everyone working in your organization feels supported to speak up if they need any kind of help, including if they are experiencing gender-based, intimate partner, or family violence. This support could form part of your organization's safety and diversity, equity, and inclusion (DEI) commitments and programs. Direct some of your corporate giving and employee volunteering efforts toward community organizations and non-profits that focus on community safety. Host forums that encourage discussion about the role that businesses play in contributing to safer communities for everyone. Such events could be in collaboration with other businesses, community organizations, or with a chamber of commerce in your community.
Educators	Ensure that your school or classroom is a respectful and inclusive environment where students feel supported to speak up. Talk with your students about the mass casualty, the Commission, and this Report, encouraging discussion about the recommendations and collective responses to terrible events and shared challenges. Help your students learn about gender, healthy masculinities, and power, encouraging them to think about ways of being that are inclusive and safe for all. Talk about the importance of bystander intervention. Lead and provide opportunities for research projects in colleges and universities to address the gaps identified in Volume 3, Violence.
Children and youth	Talk with your parents, families, friends, and teachers about your ideas to make your community safer. Seek help from someone you trust or a dedicated support organization if you or someone you know is experiencing any kind of violence or mental health issue, or just generally needs help.

Turning the Tide: Concluding Request and Encouragement

No one can undo the perpetrator's actions or the actions taken by others in response: these actions are the epicentre of concentric circles of impact caused by the April 2020 mass casualty, along with its precursors and aftermath. The ripple effect of the mass casualty cannot be erased. Steps can be taken, however, to arrest its path from extending ever outward and becoming more all-encompassing. Collectively, individuals, communities, Nova Scotia, and Canada can learn from this incident and work together toward enhanced safety and well-being in the future. An appreciation of the depth and breadth of this ripple effect is an essential component of effective, concerted, forward-looking efforts. The recommendations of this Commission can create a sea change that will absorb these ripples over time and usher in opportunities – marking a shift toward the future. It is time to turn the tide together.

In this Report, we added a second image and dimension to our framework to complement the ripple image and mark a shift toward the future: turning the tide together. This tide metaphor also signifies the transition from the Commission to those charged with implementation: governmental institutions and agencies, community-based organizations, communities, and individuals both in their professional roles and as citizens. Our work ends with the completion of this Report, but more difficult work lies ahead. Although some reforms have been undertaken since the mass casualty, many of the lessons to be learned from the systemic failures have yet to be considered – and, critically, acted upon. Given this circumstance, some of the recommendations in this Report require profound changes to institutions and to the ways agencies and communities work together to create an effective public safety system. The recommendations also encompass measures to encourage cultural shifts – measures that necessitate changes at the individual, relationship, community, and societal levels. In short, our recommendations call for a whole of society response and engagement.

"Turning the tide" is an expression used to describe a significant change in direction, including by going against an existing current or pattern within society. Turning the tide requires community, political, and institutional leaders to help shape a counter-current as well as the momentum to establish and support new patterns.

The most powerful currents are created by many people working together as a community. It is our hope that this Report will harness the outrage and compassion needed to create a wellspring of commitment to the substantive changes required to restore trust and enhance community safety and well-being, followed by the actions needed to implement those changes. Turning away from the responsibility to see, feel, and act in response to the mass casualty and its antecedents is unimaginable. In light of the traumatic losses and continuing impact of the mass casualty, facing the tide and turning it in a new direction is the only acceptable course. It is also our hope that our recommendations, many of which were contributed by Participants and the public, have two key results: they assist in shaping this momentum to turn the tide on violence; and they strengthen our resolve not to accept the current reactive responses to it.

We chose the tide metaphor in part out of recognition of Cobequid Bay, an inlet of the Bay of Fundy. The bay's name is derived from the Acadian spelling of the Mi'kmaw word We'kopekwitk, as the area was called. The shores of Cobequid Bay are important to many people living in Colchester, Cumberland, and Hants counties – in Mi'kma'ki. The April 2020 mass casualty is the most fatal mass shooting in Canadian history, and it occurred in a series of rural communities beginning on Cobequid Bay's northern shore. Now is the time to act collectively to change the course of the tidal wave of violence that was set into motion many years ago, that reached a critical point on April 18 and 19, 2020, and that continues beyond this time and place. Turning the tide requires both a reckoning with this past and accepting responsibility to contribute to a safer future.

Everyone has a role to play individually and collectively to achieve this shared, communal goal. The first step is to stand against the tide: to resist coming to premature conclusions or relying on pre-existing judgments about the mass casualty and the response to it and, instead, to read this Report with an open mind. Ideally, this first act will lead to more engagement: reflecting on the contents and recommendations and, crucially, talking about it with family, friends, and colleagues. After that, many paths will open up: with or against the tide, in the central stream of change, or at its edges. These are decisions that we each will make and, as a result, each of us in our own way will be a part of the ultimate response to the mass casualty and its aftermath.