James Smith Cree Nation / Weldon Mass Casualty Event

September 4th - 7th, 2022

Submitted to:
Assistant Commissioner
Rhonda Blackmore
'F' Division Commanding Officer

April 28th, 2023

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Introduction

In response to the tragic events that occurred in the Saskatchewan communities of James Smith Cree Nation (JSCN) and Weldon on September 4th, 2022, the Commanding Officer of 'F' Division, Assistant Commissioner, Rhonda Blackmore (CO Blackmore) initiated an internal review of the RCMP response to the event. This review, through an assessment of specific objectives, would seek to determine: whether lessons-learned and recommendations that stemmed from past mass casualty events had been adopted; whether the RCMP's response to this event was effective; and to identify and make recommendations for improvements.

RCMP Policy, and specifically 'F' Division Policy, dictates the threshold of whether an internal review is warranted for the vast array of incidents that occur in the policing environment. By ***September 13th, 2022***, CO Blackmore commenced the process of recommending a review by way of a Mandate Letter (see Appendix 'A') sent to 'K' Division RCMP Criminal Operations outlining specific objectives. By ***September 28th, 2022***, the 'K' Division Office of Investigative Standards and Practices (OISP) from Edmonton had been tasked with providing an objective and thorough examination focused primarily on the response of the RCMP, with an emphasis on the initial call for service, command structures that were utilized, public alerts, media relations, operational communications, victim care/response, over arching policy, and pre-event intelligence (see Appendix 'B').

Review Team

After being tasked to lead this review, the first step was to establish a team of Subject Matter Advisors to assist. ***Major Case Management*** principles were utilized throughout the review process; however, the first step was to create a Review Team Command Triangle (CT). An early CT decision was made to draw on investigative resources from outside of 'F' Division and additionally, to reach out to municipal partners for assistance. Team members were selected nationally, based on their expertise relating to the identified objectives. The entire Review Team included the following:

Line Officer (LO): Chief Superintendent Kevin Kunetzki, 'K' Division Criminal Operations;
Team Commander (TC): Staff Sergeant Ryan Breitkreuz, 'K' Division Office of Investigative Standards and Practices;
Primary Investigator (PI): Sergeant Jeff Mulroy, 'K' Division Office of Investigative Standards and Practices;
File Coordinator (FC): Sergeant Candace Robinson, 'K' Division Office of Investigative Standards and Practices;

Investigative Advisors:
Sergeant Kevin Misiwich, 'K' Division Office of Investigative Standards and Practices;
Superintendent Gord Corbett, 'K' Division;
Superintendent Scott McMurchy, 'D' Division;
Inspector Shawn Pike, Winnipeg Police Service;
Inspector Chris Boucher, National Headquarters;
Staff Sergeant Chris Johnson, 'D' Division
Staff Sergeant Dean Grunow, 'K' Division;
Staff Sergeant Bryce Long, 'K' Division;
Staff Sergeant Cory Francis, Winnipeg Police Service;
Staff Sergeant Clint Grabowski, Calgary Police Service;
Staff Sergeant Bill Krull, Edmonton Police Service;
Sergeant Carolyn Arsenault, 'D' Division;
Sergeant Chris Massart, 'D' Division;
Sergeant Pat Frey, 'K' Division;
Sergeant Katherine Severson, Calgary Police Service;
Sergeant Amberia Sovdi, 'E' Division;
Sergeant Jackson Bernard, National Headquarters;
Sergeant Aaron Ewert, 'K' Division;
Constable Vernon Hagen, 'K' Division;
Rob Cyrenne, 'D' Division;
Fraser Logan, 'K' Division;
Steve Cox, 'K' Division;
Heather Russell, 'F' Division; and
MCM Support: Michelle Hounsell, 'F' Division

Independent Observer:

An ***Independent Observer*** was incorporated into the review to act as a liaison to the JSCN community and provide cultural guidance to the Review Team. ***Jason Stonechild***, the Independent Observer, is the ***Executive Director of Justice of the Federation of Sovereign Indigenous Nations (FSIN)*** and retired Deputy Police Chief of the Prince Albert Police Service. He was integral in establishing connections to the JSCN community members and ensuring any communication was culturally appropriate and sensitive to their needs, at that time. Mr. Stonechild was invited to participate in all briefings and was provided access to all information available to the Review Team.

Comments from the Independent Observer:

Following the tragic event that occurred on September 4th 2022 within the First Nation communities of James Smith, Chakastaypasin and Peter Chapman, and the community of Weldon, Saskatchewan; Assistant Commissioner Rhonda Blackmore directed a

thorough and comprehensive review of the RCMP's response to this event. The intention of this review was to ensure transparency and accountability in support of the RCMP's effort to maintain public trust.

I must start by addressing the people of the Three-Nations of James Smith; I have observed incredible strength from your people, First Nations are resilient because we have become accustomed to trauma. Our Nations are in crisis and our people need justice system actors that we trust and who are compassionate to the historic and continued traumas endured by First Nations.

This role of an independent civilian observer in relation to this review is a unique practice; such reviews, particularly reviews that are connected to significant events like the James Smith tragedy; could unveil many success stories along with potential mistakes. These reviews are done by teams that are external to the group being reviewed and typically consist of police professionals only. The addition of a civilian oversight that represents all First Nations within the Province of Saskatchewan was a true representation of the Saskatchewan RCMP's commitment to reconciliation through inclusion and transparency. I commend Assistant Commissioner Blackmore for her leadership and authentic interest to work with First Nations to address many justice issues that affect our people.

As such, I have the following opinions based on this review:

1. *The team developed for this review is professional, highly competent, impartial, and were aligned to achieve the best outcome.*
2. *The review included external stakeholder consultation that was appropriate and represented the interests of the communities.*
3. *Community concerns regarding the RCMP's response were explored and included within the team's findings.*
4. *I am confident that the RCMP, under the leadership of Assistant Commissioner Blackmore, has a sincere interest in First Nation wellness issues.*
5. *I believe the findings contained within this report are accurate and meaningful.*

I would like to acknowledge the professionalism and competence of the team, in particular Chief Superintendent Kevin Kunetzki, Inspector Ryan Breitkreuz, Sergeant Jeff Mulroy, and Sergeant Candace Robinson. Their expertise and dedication drove this review in a compassionate and meaningful manner, I thank each of you for the respectful treatment and inclusion I experienced throughout this journey.

I take great pride as a servant to our people and to our First Nations leadership. The Federation of Sovereign Indigenous Nations is a strong organization that protects the

Inherent and Treaty Rights of First Nations, we do so through collaborative relationships, advocacy and supporting our Nations people. I acknowledge Chief Bobby Cameron and Vice Chief Edward Lerat (Justice Portfolio Executive), in addition to our Executive Chiefs at the FSIN as they have fully supported our efforts regarding this review and efforts in support of James Smith, Chakastaypasin, and Peter Chapman. Without the Chiefs support my role as a civilian oversight would not have been an option.

I am honoured with the privilege of being part of this review, I truly hope that its findings will assist community safety wellness for First Nations and non-Indigenous communities moving forward and will assist the RCMP as they strive to maintain the trust of the people they serve.

Ekosi, that is all;
Kinanâskomitin, Thank you,

Jason Stonechild,
Executive Director of Justice, Federation of Sovereign Indigenous Nations.

Purpose of Review:

Perhaps the clearest way to define what this review encompasses, is to discuss not only what it is, but also what it is not. The purpose of this review is ***not to conduct a forensic audit*** of the investigation but rather to describe the review findings related to the RCMP response to the JSCN/Weldon event, outline what was effective, what improvements can be made, and to provide realistic and meaningful recommendations with supporting rationales.

This is an ***internal review*** with specific objectives, and it differs from more publicized review processes (below) that have already been declared, or may be in the future.

Coroner's Inquest:

On ***September 22nd, 2022,*** the Chief Coroner of Saskatchewan announced that an inquest into the 11 deaths was to be undertaken with a mandate of reviewing the circumstances surrounding each homicide. Although no date has been set for the Coroner's Inquest, the Chief Coroner advised that it would be held only after the police investigation was complete.

Saskatchewan Serious Incident Response Team (SIRT) Investigation:

SIRT is an independent, civilian-led unit responsible for investigating serious incidents involving police officers in Saskatchewan. Investigations will occur when a person suffers serious injury or death, either in police custody or as a result of a police officer's actions.

SIRT is conducting a separate investigation, ***examining the in-custody death of the suspect***. This is an on-going investigation.

Correctional Services of Canada Review:

The ***Correctional Service Canada (CSC)*** and ***Parole Board of Canada (PBC)*** have convened a ***National Joint Board of Investigation (BOI)*** into the Statutory Release, community supervision, and PBC decision in the suspect's case. This investigation is to be guided by the requirements set out in the Corrections and Conditional Release Act ***to examine and analyze all the facts and circumstances, including whether laws, policies and protocols were followed***, and to identify any recommendations and corrective measures. Currently, it is not known when the results of the National Joint BOI will be released.

Public Inquiry:

At this time a Public Inquiry into the JSCN/Weldon event has not been called, but one still could occur and thus, will be briefly explained. A ***Public Inquiry*** is an official ***independent process*** designed to examine issues or events that have had a significant impact on the public. Public Inquiries are established to fully and impartially investigate issues of national importance and are led by experts or judges that have the ***power to subpoena witnesses***, take evidence under oath, and request documents. A Public Inquiry would also examine the details of the investigation, to better account for the actions of the offender(s). The resultant findings and recommendations have a significant impact on public opinion and the shape of public policy.

It is unknown at the time of this document whether a Public Inquiry will be instituted to review the JSCN/Weldon event.

Review Objectives and Methodology:

The Review Team travelled to Saskatchewan during the week of ***October 17th to 21st, 2022***, in order to conduct interviews with those key participants in the RCMP response. During the course of the week, over 60 members of the RCMP, including those in senior

leadership roles, members in specialized units, members that were first on scene, media relations, and telecoms operators, were spoken to and provided valuable feedback as to their role in the event. Although participation was not mandatory, all that were asked to provide input cooperated fully.

During these interactions, the goal was to establish a clear understanding of what occurred, acknowledge instances where improvements can be made, and collaboratively develop achievable recommendations.

Prior to commencement of this review, the original intent was to document findings within each objective, separately. As the review progressed; however, it became readily apparent that ***very little of what took place occurred in isolation***, making the task of detailing each objective independent of the others, impracticable. The Review Team was led by the information that they were receiving and soon after commencement discovered, due to the dynamic and evolving nature of the overall event, multiple instances of overlap and cross-referencing of information amongst the various sections. As such, reporting the findings as laid out below became the manner in which to best document the assigned objectives.

The report methodology included a review of the information obtained from review interviews, including any subsequent follow up. Further, information and reporting on the overall event was documented on the Police Reporting and Occurrence System (PROS) by the involved RCMP members. The Review Team was granted access to the PROS file as part of this review which allowed for reference of relevant documents or information in order to provide further context, when required. It is important to note the review was not exhaustive, nor all-inclusive; however, it was conducted in such a manner that strategically focussed findings and useful recommendations were derived.

The following areas were recognized as the more significant components of the Divisional and National response and will be expanded upon throughout this document:

- Initial Response;
- Command Structure;
- Major Crime Branch response;
- Air Services;
- Strategic Communications;
- Operational Communications;
- Mass Casualty/Victim Response; and
- Pre-Event Intelligence.

Past Events:

Reviews of this nature are not uncommon. The unfortunate reality is that they evolve from tragic events that have far reaching implications. Although an evaluation regarding the RCMP response to these events is inevitable, they also reveal perhaps the more important question as to whether the RCMP has learned from the past and have evolved as a result of recommendations from past events.

Previous mass casualty reviews on a National level, such as the ***MacNeil Report*** that documented the ***June 4th, 2014*** killings of three RCMP members in ***Moncton, New Brunswick*** were considered and recommendations that relate to this event, will be ***highlighted in red throughout***.

A Public Inquiry led by the ***Mass Casualty Commission*** (the Commission) into the more recent mass casualty event that occurred in ***Portapique, Nova Scotia in 2020,*** resulting in twenty-two people being murdered, concluded in late 2022. The Commission's finalized recommendations were released on ***March 31st, 2023***. Due to the timing of the issuance of this report coupled with the sheer volume of the Commission's final report, the relevant recommendations from that document are not correlated in detail, throughout this review. That being said, the accessibility of 'Foundational Documents' that were available for review allowed for a certain amount of insight into the Commission's findings.

Community Perspective:

At the recommendation of the Independent Observer, the engagement of the residents of both the JSCN and Weldon was sought, along with any feedback and dialogue related to their observations of the RCMP response to the events that affected their respective communities so deeply. This community involvement in the process became critical in understanding the nexus between the RCMP and the communities, and how to best foster a spirit of community policing going forward.

To do this, interviews with the JSCN community members were arranged in direct consultation with the Independent Observer and in collaboration with representatives from the JSCN Band Counsel and local Elder(s). These meetings were conducted in Edmonton on ***November 23rd to 25th, 2022***. Steps were taken to minimize the potential of re-traumatizing anyone from the community. Similarly, on ***January 10th, 2023***, members of the Review Team travelled to Weldon to conduct interviews with a cross section of community members.

These interviews served as opportunities for residents from both communities to voice any concerns or observations directly related to the RCMP response to their respective communities. There was an overall appreciation for the response made by the RCMP; however, there were areas of growth that were identified.

With respect to the JSCN specifically, early on in the review process it was learned that the community itself is made up of three bands: ***Peter Chapman (Chief Robert Head)***, ***Chakastaypasin (Chief Calvin Sanderson)***, and ***James Smith (Chief Wally Burns)***. For the purposes of this report, ***James Smith Cree Nation (JSCN)*** will be used to reference the location of the events that took place on September 4th; however, it is recognized that the victims from that day were comprised of members from all three Bands.

Executive Summary

Event Summary:

During the early morning hours of ***September 4th, 2022***, Melfort RCMP began receiving reports of multiple stabbing incidents in the Northern Saskatchewan community of JSCN, and later, in Weldon. Soon after the initial call, there was a realization the situation was evolving into a major event where the RCMP was confronted with the managing a mass casualty incident. A province-wide search for a suspect would last three days and culminate in an eventual arrest of the suspect, approximately 140 kilometers southwest of JSCN. In the aftermath, eleven victims would be murdered and an additional seventeen injured, resulting in one of the worst mass murders in Canadian history.

Instantaneous to the end of the mass casualty event, the process of reviewing the RCMP response to the JSCN/Weldon event was actioned by the Commanding Officer, Assistant Commissioner, Rhonda Blackmore. This report is the result of initiating that process.

RCMP Overall Response:

The RCMP response to this mass casualty event required measures be taken in the midst of a complex situation. Upon recognition of the magnitude of what was unfolding, an initial public alert was issued, to notify the public of the situation and recommend to seek shelter. Thirteen additional public alerts would be issued over the course of the event.

Throughout the days that followed, over 500 RCMP members across all business lines responded. Municipal and provincial partners were called upon to further supplement efforts to engage various response functions such as support for the victims' families, to assist with apprehension efforts, to process over 40 crime scenes that generated over 700 exhibits, and to complete a criminal investigation.

Culturally appropriate members of RCMP Indigenous Policing were summoned both from within 'F' Division and externally and assigned to key areas, allowing for constant communication between key stakeholders and the RCMP and to further provide crucial insight into culturally appropriate conduct for responding members.

Given the circumstances, multiple levels of RCMP Command were activated; different levels of Government were engaged; the Federation of Sovereign Indigenous Nations (FSIN) were involved; and National interests were prevalent.

Broad Findings:

On a broad level, the Review Team did not identify any common underlying circumstance that significantly impeded the RCMP's ability to manage the response to the JSCN/Weldon

event. At the same time, certain areas for growth were identified with the underlying purpose of enhancing responses to future, similar situations.

Throughout the document, any suggested ***recommendations*** to any of these or other identified areas will be ***highlighted and italicized*** as they are raised. An all-encompassing list of recommendations can be found at the end of the document.

In addition to any organizational gaps that were noted within the review, there were areas of effectiveness that were discussed and will be highlighted as ***effective practices*** for future responses.

Key Areas for Growth:

- Establishment of a ***command structure*** for major events;
- Improving ***community relations***;
- Conducting thorough ***risk assessments***;
- Rectifying communication and analytical gaps related to the ***triaging of high volume tip information***;
- Improvements to the ***Division Emergency Operations Centre***; and
- Enhancement of ***police radio*** coverage and ***interoperability***.

Key Effective Practices:

- The efficiency of ***sharing pertinent information with the public***;
- Conducting ***tabletop exercises*** with Senior Officers;
- The ***delegation of tasking***;
- The early establishment of ***victim support roles***;
- ***Incorporating culturally appropriate resources*** in key positions to ensure consistent communication and culturally sensitive practices; and
- Overall demonstration of ***strong senior management relations***, and ***strong working relations*** with external partners and RCMP Divisions.

Conclusion:

The RCMP are becoming increasingly challenged to manage complex critical events. In Saskatchewan alone, over the past several years, the RCMP have responded to a number of tragic events. The ***La Loche school shootings in 2016*** resulted in four people being killed and seven others injured. The ***Humboldt Broncos bus crash of 2018*** ended with sixteen people perishing and thirteen others injured. Although the circumstances of these events were unique, the fact of the matter is that they each elicited a coordinated and extensive police response. Given the frequency with which these critical events are occurring, it becomes a necessary step to use every available opportunity to identify effective practices and lessons learned in order to enhance our ability to respond.

In the wake of the JSCN/Weldon event, a review of how the event unfolded and the processes that were utilized by the RCMP can provide the opportunity to highlight strengths, expose shortcomings, and identify challenges. When conducted in a methodical and thoughtful manner, reviews of this nature can result in meaningful changes to police responses to mass casualty events and other major events alike. The hope is that the findings of this review will provoke both regional and national level discussions regarding policies and tactics during these events.

Next Steps:

This report is provided to the Commanding Officer of 'F' Division for review and will be disseminated as required. While the many recommendations provided are specific to 'F' Division policies and procedures, a goal of this review was also to ensure that the findings and lessons learned are considered by the RCMP nationally. Some recommendations contained in this report can be implemented more easily, while others will take more time and collaboration.

Chronology of Events

To offer context to the various sections of this document, what follows is a summary of the suspect's movements from his arrival on the JSCN from September 1st to his arrest on September 7th.

As will be seen below, Myles Sanderson (suspect) was not present on the JSCN until days prior to September 4th, and he fled shortly after committing multiple murders and attempted murders in both JSCN and Weldon. Part of the Major Crime Unit (MCU) investigation into these events was to determine the suspect's movements and interactions leading up to that day, in an attempt to gain further insight into how such an event precipitated. As information was acquired from witnesses and acquaintances, it became apparent there were a number of occurrences the suspect was involved in that took place prior to September 4th, several of which are noteworthy.

The MCU investigation included the analytical plotting of known events on a timeline to provide an overall account of the suspect's activity in advance of the events of September 4th and for the days that followed until his arrest on September 7th. Despite best efforts, there remain portions of time where there is little or no information available to verify the precise movements or sequence of events as much of the information was sourced from witness accounts and exact times as to the occurrence of the events were not known.

Various maps are included below and were generated as part of this review as a means to offer clarity to the reader and to illustrate various key times and locations, based off information received from the MCU Timeline.

September 1st:

Myles Sanderson (the suspect) arrived on the JSCN on ***September 1st*** with [redacted]. During this time, they were staying with Damien Sanderson (Damien) and [redacted]

September 2nd:

During the afternoon of ***September 2nd*** the suspect got into a physical altercation [redacted], assaulted her, and attempted to drive over her, outside of Damien [redacted] residence. This caused [redacted] and return home, to Saskatoon. ***This incident was not reported to police until after the homicides took place***. The

suspect remained on JSCN in the company of his brother Damien and, later that evening, the two took [redacted] vehicle and drove around JSCN selling cocaine.

September 3rd:

At some point (around midnight on September 2nd) the suspect and Damien went to [redacted] residence. [redacted] Damien got into a fight. The suspect and Damien left, eventually making their way to [redacted] ***North Road*** in [redacted] vehicle, sometime during the ***early morning hours of September 3rd***.

At ***4:03 am on September 3rd***, [redacted] reported her vehicle to police as being stolen by [redacted], Damien. While travelling to the JSCN, the responding Melfort RCMP members queried Damien on their mobile workstation and located a picture of him to familiarize themselves with his appearance should they have encountered him. Members were also aware Damien had outstanding warrants for his arrest.

Melfort RCMP members located [redacted] vehicle at [redacted] ***at 5:35 am***. When they arrived, they could hear loud music coming from a RV next door and they checked the RV for Damien before attending [redacted] Two males were located in the RV who appeared very intoxicated. The males provided their names to the police but were not requested to provide identification as neither of them matched the description of Damien.

RCMP members then attended [redacted] the identified resident. [redacted] advised members that Damien was not there. She did not know his whereabouts, or how [redacted] vehicle arrived at her residence. The members entered the residence to search for Damien and found a number of people, including three adult males who did not match the description of Damien. The keys to [redacted] vehicle were found on the kitchen table and were returned to [redacted], who attended the residence after being notified by police that her vehicle was recovered.

The Melfort RCMP members left [redacted] and continued to search for Damien on the JSCN, attending locations provided to them by [redacted] as places Damien could be located. The members spoke to [redacted] several times that morning (believed to be 8-10 times) and [redacted] made no mention of anyone else with Damien when he took her vehicle, and at no point was the suspect, Myles Sanderson, discussed.

Throughout the day, Damien and the suspect ***travelled to Kinisinto*** to get food and then back to the JSCN where they went back and forth between various residences. At around ***5:00 pm***, the suspect and Damien went to [redacted] residence at [redacted] Edward Burns Avenue and while there, the suspect commented that he was ***'there for one body'***

referring to [redacted]. [redacted] eventually showed up to the residence and was assaulted by the suspect. ***There is no record of this incident being reported to police until after the homicides.***

Following this assault, Damien went to the Kinistino Bar with [redacted]. While at the bar, Damien made a comment to a [redacted], stating that that he and the suspect ***had 'a mission to do'***. Damien was eventually dropped off at a [redacted] place. It is unknown where the suspect was at this time.

At ***approximately 11:00 pm***, [redacted] returned home to find the suspect sitting on the stairs outside of his house, at [redacted]. The suspect departed and said that he was going to go look for Damien. The two eventually re-connected and arrived at [redacted] and while there, physically assaulted [redacted] before leaving and going to [redacted] residence where they remained until the ***early morning hours of September 4th***.

September 4th:

At ***approximately 2:00 am***, the suspect and Damien went to [redacted] residence, took her Grey Dodge Caravan and sold cocaine for a time until returning back to [redacted]. At ***approximately 4:45 am*** the suspect and Damien were at [redacted] and were said to be ***'guzzling booze' to 'pump themselves up'***, prior to departing again, in the Grey Dodge Caravan.

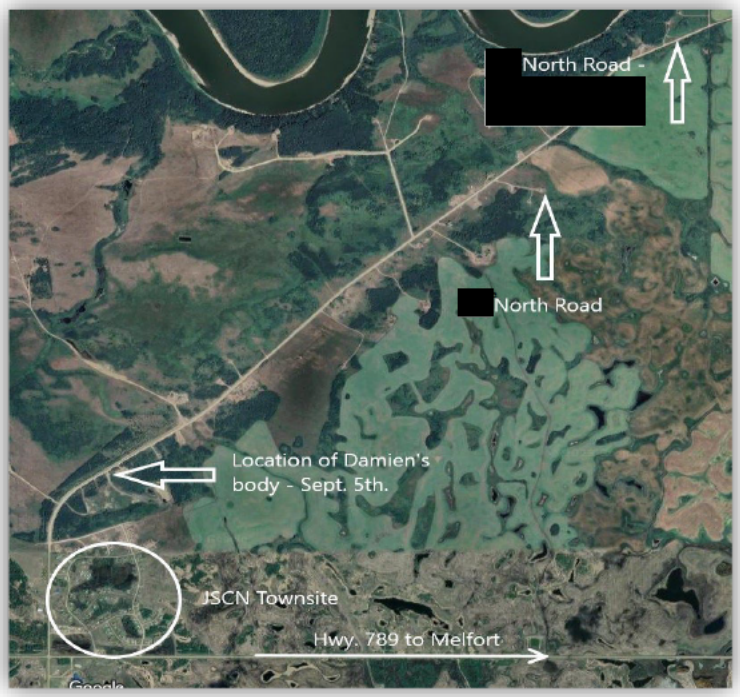
At ***approximately 5:30 am***, the suspect and Damien entered [redacted].

After searching the house [redacted], Damien told [redacted] that it would be ***the last time that she would see him***. Damien then took [redacted] cell phone and departed the residence with the suspect. From there it is believed that the suspect and Damien traveled to [redacted] ***North Road***, still in the Grey Dodge Caravan.

[redacted] North Road:

At approximately ***5:40 am*** the suspect and Damien entered the residence located at [redacted] ***North Road*** and initiated an altercation with the homeowner, [redacted]. The suspect tried to stab and kill [redacted], at which point Damien was said to have intervened. [redacted] sustained ***non-fatal stab wounds*** prior to the two departing. This altercation ***resulted in the initial call to the RCMP*** relating to the events that were about to unfold. Additionally, it was the information from this complaint that was used in the first Public Alert that ***identified both the suspect and Damien, as being responsible for the spree of violence.***

After departing in the Grey Dodge Caravan, the ***suspect stabbed Damien multiple times*** while inside the vehicle. Damien was able to exit the van and wandered off the road where he would later succumb to his injuries. ***Damien's body would not be discovered, however, until 11:25 am the following day (September 5th).***

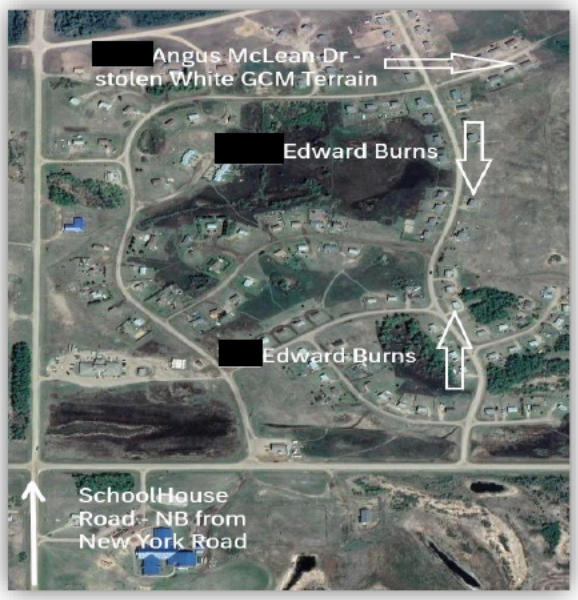


[redacted], New York Road:

After killing Damien **(Homicide 1)**, more ***stabbings were reported shortly after 6:00 am, at*** [redacted] ***New York Road,*** a location approximately 12 kilometers southwest of the original call to police [redacted]). The suspect crashed the Grey Dodge Caravan into [redacted] and after gaining entry, stabbed [redacted] multiple times before leaving on foot to [redacted] residence at [redacted]. [redacted] would be found deceased **(Homicide's 2, 3, and 4)** and [redacted] injured. This was the first location that the Melfort RCMP would attend at approximately 6:23 am. The suspect took [redacted] ***White Ford F350*** truck from [redacted] and departed.

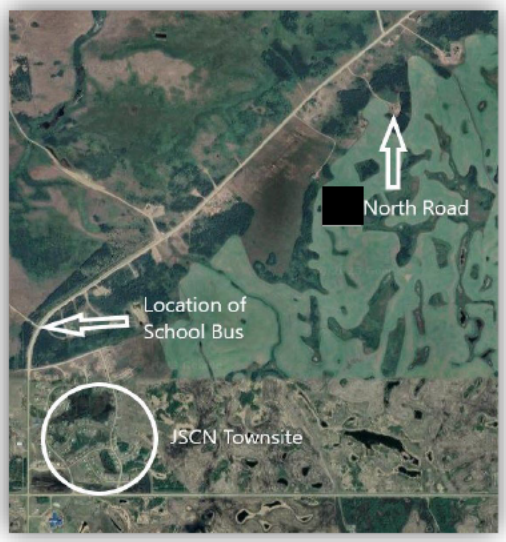
[redacted] Edward Burns Avenue:

From New York Road, the suspect ***travelled north toward the 'town site'*** of the JSCN (approximately 6 kilometers away) and eventually to [redacted] ***Edward Burns Avenue*** where he attacked and injured [redacted] at approximately 6:14 am, before abandoning the White Ford F-350 and ***proceeding northbound on foot*** to another nearby home at [redacted] ***Edward Burns Avenue***, where he stabbed and killed [redacted] **(Homicide 5)** and injured [redacted].



[redacted] North Road:

The suspect remained in this area, on foot and ***stole a White GMC Terrain*** from [redacted] Angus McLean Drive and, by ***6:19 am***, had driven to [redacted] ***North Road*** (the area where the original assault occurred at 5:40 am). It was here that the suspect attacked [redacted], with a knife. The suspect stabbed [redacted] several times while [redacted] sustained non-fatal wounds. Both the suspect and [redacted] drove away from the residence; the suspect in the White GMC Terrain and [redacted] in a school bus. [redacted] eventually succumbed to his injuries and would later be ***found deceased*** **(Homicide 6)** in the school bus approximately 2.5 kilometers southwest of his residence.



It was around this point in time (***6:20 am***) that the first two ***RCMP members arrived at the JSCN*** and began the process of determining the extent of the victims and scenes based on the calls that had already been received and the severity of injuries to the victims. ***RCMP initially attended to [redacted] New York Road*** as they thought this was the first homicide scene. As mentioned, ***Damien is believed to have been the first murder victim; however, his death was not known to RCMP and his body had yet to be discovered.*** One RCMP member remained at [redacted] New York Road and the other, proceeded northbound (approximately 10 kilometers) to the original call for service to [redacted] North Road, arriving there at ***6:32 am***.

[redacted] Abel McLeod:

After making an assessment at [redacted] North Road, the member departed south to the town site and [redacted] ***Abel McLeod*** (approximately 5.5 kilometers) as there was a report of ***two more deceased*** at that location. Upon arrival [redacted] **(Homicide's 7 and 8)** were found murdered with [redacted] sustaining injury. While driving to [redacted] Abel McLeod, ***RCMP passed the school bus*** in the ditch that [redacted] had used; however, were unaware that he was deceased at this point in time. [redacted] would not be discovered until 8:28 am on this date.

Watchguard camera footage – A430

[redacted] Melrose Place:

Prior to RCMP attending to[redacted] Abel McLeod, the suspect had ***abandoned the White GMC Terrain*** and travelled northbound on foot to [redacted] ***Melrose Road***, where he attacked and injured [redacted].

At this point in time it is unknown if the suspect was aware the RCMP had arrived on the JSCN as RCMP members were responding to locations that were not within immediate vicinity of the suspect.

The suspect remained in the 'town site', on foot where he proceeded to [redacted] ***Angus McLean*** where he injured [redacted], then to [redacted] ***Melrose Place***, then to [redacted] ***George Burns Lane*** where he attacked and injured [redacted] prior to stealing their ***Red Dodge Caravan***.

Return to [redacted] Edward Burns Avenue:

After abandoning the Red Dodge Caravan, the suspect returned to [redacted] Edward Burns Avenue where he had previously killed his 5th victim [redacted] and proceeded to ***kill*** [redacted] **(Homicide's 9 and 10)** before travelling on foot and breaking into a nearby home at [redacted] ***Abel McLeod*** Street, and stealing [redacted] ***Black Nissan Rogue***.

During this time ***RCMP had arrived at [redacted] Abel McLeod Street*** and observed the ***White GMC Terrain***. The responding member was of the belief that this was the suspect vehicle at the time and was not aware ***that he was currently in the Black Nissan Rogue, a few houses to the north.*** Due to the close proximity of the two homes it was possible that the suspect would have seen the RCMP patrol car and could have been the first instance

the suspect was made aware of the RCMP presence on the JSCN and may have ultimately brought about his departure from the community.

Relative distance [redacted]

Watchguard camera footage – A430

Suspect departs southbound - School House Road:

The suspect, still in the Black Nissan Rogue, departed southbound approximately 3 kilometers from the JSCN town site to [redacted] School Road where he injured [redacted].

Kinistino to [redacted], Weldon:

By ***7:00 am*** there were reports the suspect had arrived ***in Kinistino***, some 27 kilometers southwest of JSCN, looking for gas. Following this, the suspect travelled 12 kilometers west to Weldon, where at ***7:10 am*** he broke into [redacted], and killed his last victim, [redacted]. **(Homicide 11)**.

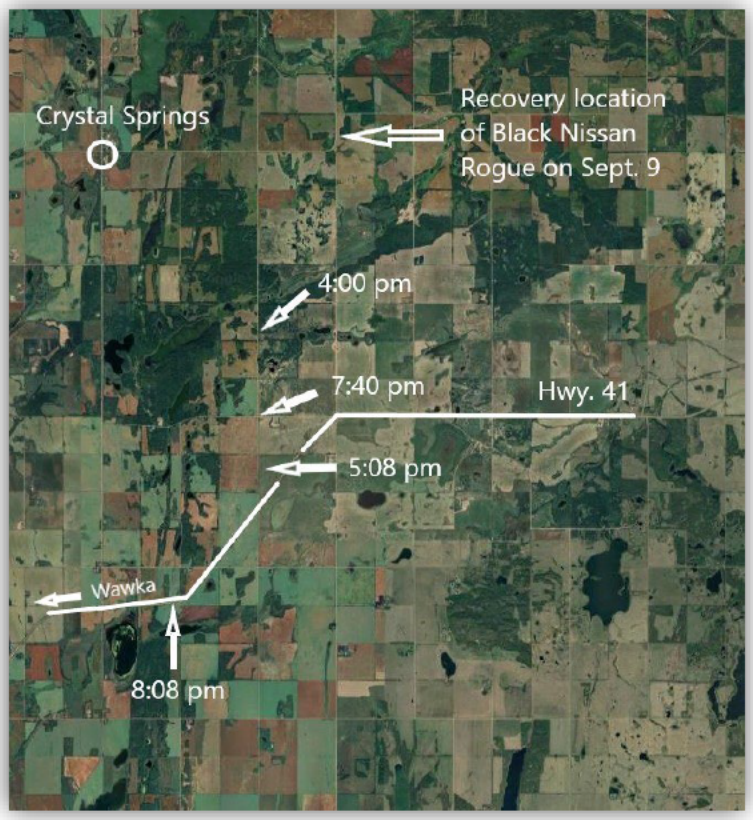
At ***7:12 am***, the ***first of a number of Public Alerts*** was broadcast by the RCMP advising the public of the stabbings on the JSCN and for residents to seek shelter.

Following his last murder, the suspect was observed at various locations in Weldon rummaging through vehicles and requesting assistance from various community members as he advised that he had been stabbed. The suspect was observed to be covered in blood by witnesses. At ***7:24 am*** the Black Nissan Rogue was observed on video travelling south, presumably out of Weldon.

At ***7:57 am the Second Public Alert was issued*** that named the suspect and provided both his physical description and the vehicle he was believed to be driving in.

Highway 41 sightings:

Between 4:00 pm and 8:08 pm there were reports of sightings of a lone suspect (Myles Sanderson), near Highway 41 between Melfort and Wawka. ***By this time Damien had been killed; however, his body would not be discovered until the following day.*** One of the complainants knew the suspect personally through a family connection. Wawka RCMP responded but did not locate either the suspect or the Black Nissan Rogue.



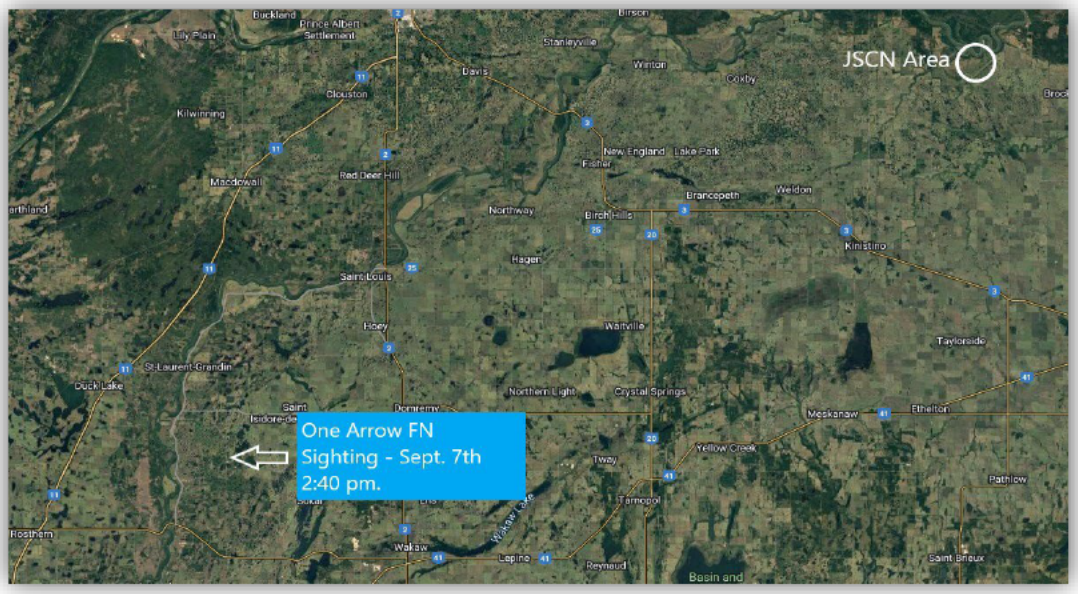
<u>September 7th:</u>

Crystal Springs area:

At ***2:06 pm***, [redacted] called 911 to report a break, enter, and theft of her White Chevy Avalanche from her residence located near Crystal Springs.

One Arrow First Nation:

At approximately ***2:40 pm***, [redacted] reported the suspect at his residence located at House [redacted] ***One Arrow First Nation***. The suspect was outside his residence asking for ride to the city. [redacted] said that his truck was not working and watched the suspect leave westbound at a high rate of speed, in the White Chevy Avalanche.



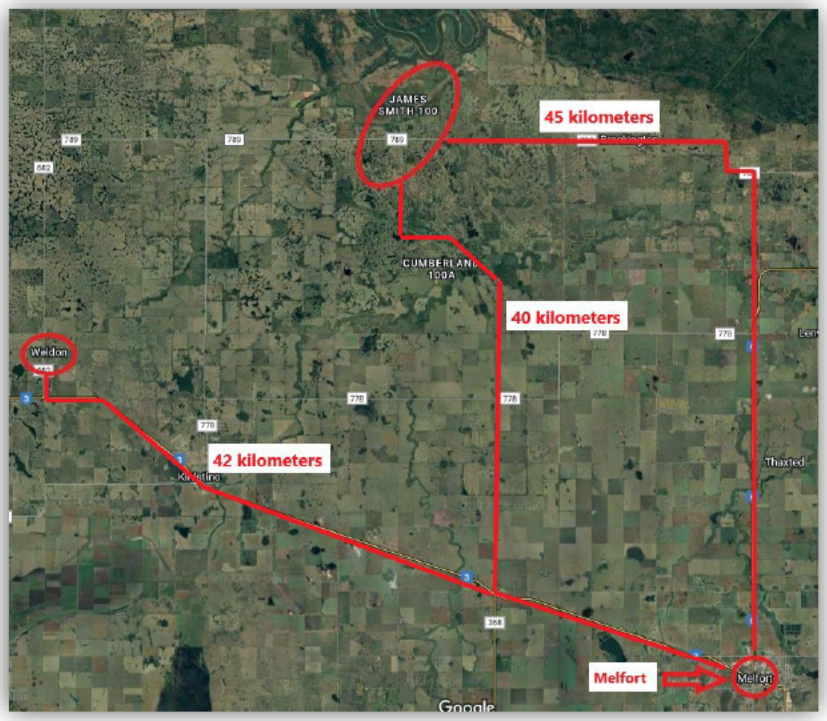
At ***3:17 pm*** an unmarked police vehicle located the White Chevy Avalanche travelling west bound toward Rosthern on Highway 312. Eventually the suspect realized that he had been detected, began to flee from police, and a pursuit ensued. The suspect was eventually travelling southbound in the northbound lane of Highway 11 (toward Saskatoon) until the RCMP forced the White Chevy Avalanche off the road south of Rosthern at ***3:32 pm***.

The suspect was arrested and went into medical distress immediately following. ***EMS transported the suspect*** to hospital in Saskatoon at ***3:51 pm***; however, he was declared ***deceased at 4:38 pm*** despite efforts made to revive him.

Initial Response

Prior to a review of any response to the initial call(s) related the JSCN/Weldon event, an overview of the Melfort RCMP Detachment, the affected communities, and the process by which 911 calls are dispatched is required to offer context to the situation.

The ***Melfort RCMP Detachment*** is responsible for policing the communities of JSCN and Weldon. The JSCN is located approximately 45 kilometers northwest of Melfort, has a population of approximately 1,800 people, and spans an area of approximately 150 square kilometers. Weldon is a small village of approximately 200 people located 42 kilometers northwest of Melfort.



Overview of distances between Melfort and JSCN/Weldon

At full compliment, the Melfort Detachment has sixteen uniformed police officers. The detachment is lead by a Staff Sergeant, including two Corporals, and thirteen Constables. Eleven of the Constables are committed to general duty detachment policing, ***one Constable is assigned as a dedicated First Nation Position (FNP)*** and one Constable

is assigned as a Court detail member. The Tisdale Detachment is located approximately 40 kilometers east of Melfort and has an amalgamated shift schedule with the Melfort Detachment. A full member compliment at Tisdale Detachment is eight uniformed police officers, including one Sergeant, one Corporal, and six Constables.

On the date of the JSCN/Weldon mass casualty event was there were ***thirteen operational members at the Melfort Detachment and six at the Tisdale Detachment***.

[redacted]

As will be discussed later in this section, during the initial call for service to the JSCN, there was a dayshift member that was on-call (but in the office), and another member that was their back up (at home). ***(RCMP OM – ch. 16.9 Backup)***

In an effort to support further resources for the JSCN/Weldon event, a ***Protection and Response Team (PRT)*** call out was initiated through the Government of Saskatchewan where a number of Conservation Officers and Highway Patrol Officers in the area responded.

The Government of Saskatchewan's PRT was created in 2017 as an initiative to assist with crime reduction in rural Saskatchewan. The program is designed around ***Highway Patrol Officers*** and ***Conservation Officers*** with expanded powers working with police officers from the RCMP and municipal police services in the province with a goal of improving police response to emergency calls for services.

The 911 Call(s):

The ***Saskatchewan Public Safety Agency (SPSA)*** provides province-wide access to 911 emergencies through the Sask911 system. Emergency calls for police, fire, rescue or emergency medical services are taken by trained 911 operators. These trained call takers determine the nature of an emergency and transfer the call to an emergency dispatch operator.

In Saskatchewan, 911 calls are taken by ***Public Safety Answering Points (PSAP)*** in Regina, Saskatoon, and Prince Albert. Outside the municipal boundaries of Saskatoon and Regina, 911 calls are answered in Prince Albert.

The 911 calls related to the JSCN/Weldon Mass Casualty Event were first answered by the PSAP in Prince Albert, where they were initially assessed as police, fire, or ambulance, and then transferred to the Division Operational Communication Centre (OCC) when

found to be police-related. This will be further discussed later in the ***Operational Communications*** section of the review.

Tactics and Response to Initial Call:

In general, police respond to types of situations that are either under control, where there is no longer a threat to public or police safety; or evolving, where information may be limited and there is imminent danger to the public and/or police. The type of situation will dictate whether the actions taken by initially responding members are more investigative or tactical.

Constable Tanner Maynard (Constable Maynard) of the Melfort Detachment was contacted by the OCC at approximately 5:44 am. Constable Maynard was already at the Detachment as he had been called out previously, on an unrelated call. The initial complainant reported that the suspect and his brother had broken into the complainant's house and stabbed him, causing non-fatal injuries. Both the suspect and his brother had since departed in an unknown direction.

Following dispatch, and as per policy, Constable Maynard immediately called his back up, Constable Dave Miller (Constable Miller), to assist. When Constable Miller arrived at the detachment, Constable Maynard was waiting in his police vehicle. Constable Miller joined Constable Maynard and both departed in the same vehicle to the JSCN, ***approximately 9 minutes*** after being dispatched. ***At this time, there was only one complaint that had been received and the members were responding to what they thought, was a single stabbing with the suspects having already departed from the scene***.

While travelling to the JSCN, the OCC and the Member Operational Support Services (MOSS) Unit (explained later) were updating the members. The situation was clearly evolving rapidly, as both the number of victims and scenes were learned to be increasing. Once on scene, Constables Maynard and Miller relied on information from the initial and subsequent complaints (provided by the OCC and MOSS) coupled with their own observations to make tactical decisions, which will be reviewed as part of this objective.

Ops Manual Ch. 16.9.3.1 outlines that when responding to an incident, members must conduct a risk assessment in accordance with ***Ops Manual Ch. 17.1 (Incident Management Intervention Model)*** that will be discussed below.

Upon arrival at the initial scene at the JSCN, some ***28 minutes*** after departing Melfort, the initial responding members began attending scenes, starting first with the report from [redacted] on New York Road. When the first deceased victims were discovered at this location, Constables Maynard and Miller discussed their strategy moving forward. They had very little time to develop a plan as information continued to be received as the situation was evolving. A decision to separate at that time was made, leaving Constable Miller to provide first aid and to maintain scene continuity ***(Ops Manual Ch.1.2.2.4),*** at what they believed were the first homicides. Constable Maynard then attended the more northern location of the initial call for service while continuing to triage additional victims and scenes as he was made aware of them. At this point, they did not know where the suspect(s) were and the number of victims and scenes were continuing to rise, as outlined above, in the ***'Chronology of Events'***.

One or Two-Person Patrol Cars:

This review identifies that Constable Maynard and Constable Miller are to be commended for their actions as they relate to their overall response to this event. Their work was outstanding, in a situation that was ***incredibly difficult***. They were quick to respond, decisive, and they faced unimaginable challenges.

With this being clear, in this circumstance, the members' decision to separate put them at a tactical disadvantage, at least for a period of time. The suspect(s) were still at large (believed to be two at that time), and when Constable Maynard arrived at [redacted] North Road, the two members were then about 12 kilometers apart. Portable reception on JSCN was also poor, which will be discussed at later points in this review, and Constable Miller had no means to back up Constable Maynard, had he (Constable Maynard) encountered the suspect(s). Alternately, had the suspect(s) returned to [redacted] New York Road, Constable Miller would have been alone. Although this circumstance did not materialize, it is worth analyzing the circumstances and potential risks that come from this situation.

A further question becomes, however, were they at a tactical disadvantage only due to their separation at that time, or was it in part also due to the decision to travel in a single patrol vehicle at the outset? This question is complex, and organizationally ***there is not yet national policy or guidance on the issue of one or two-person patrols.*** Depending on what had happened, some might say they were better to have travelled in the same patrol car, if they hadn't separated. They would have had at least two of them, together, if they had then encountered the suspect(s). Alternatively, some might argue that travelling in separate vehicles would have allowed them the ability to cover more

ground, to search for the suspect(s), and attend other calls, while still ensuring they remain close.

While the advantages and disadvantages of one or two-person patrol cars are still being debated today, it could be said here that two-person patrols are more common, in large municipalities, where generally more resources are available, within a close proximity. And while some will argue for, and some against, two-person patrol cars in large municipal environments, it becomes less clear on what is the best tactical option for rural environments, or where there are only two members initially available.

The most obvious solution would be to always deploy the maximum number of members with the maximum number of patrol vehicles possible; however, the reality is this scenario is seldom available in rural policing environments, today. This being the present reality, the organization would benefit by analyzing this issue in greater detail. Part of this analysis should call attention to the risks of separation, regardless of the decision to have one or two-person patrol cars.

Recommendation 1.1 - Consider Divisional and / or National level policy direction and/or training around the issue of one or two-person patrol vehicle responses. Include a discussion of the risks relating to the separation of resources, when there are only two members to respond. Policy and/or training should not be prescriptive, but rather framed in a way that can assist members to best consider the risks and make the most effective decisions accordingly.

The Incident Management Intervention Model (IMIM):

The IMIM is what RCMP officers use to assess and manage risk in all encounters with the public. This model is used mainly as a guideline to assist an officer in articulating their decision-making process involved in selecting a particular intervention option. ***The responding members were never compelled to physically engage the suspect upon arrival at the JSCN during the initial call, therefore there is no question as to whether the appropriate intervention tool was used at that point in time.*** Having said that, consistently found in all components of the IMIM is the notion of mere officer presence being a key factor in intervention. As pointed out above in 'Chronology of Events', the point at which the suspect may have first observed the RCMP members on the JSCN could have contributed to his departure from the community.

When making a determination of level of intervention that is necessary under the circumstances, the various stages of the IMIM illustrate the necessity to ***constantly evaluate risk*** throughout a situation.

The Melfort RCMP Detachment Commander, Staff Sergeant Darren Simons (Staff Sergeant Simons), was contacted by the ***MOSS Unit*** shortly after the initial dispatch and was advised of the situation. The MOSS Unit will be detailed in the ***'Command Structure'*** section of this document; however, to offer context at this juncture, the MOSS Unit is staffed with Senior RCMP Non-Commissioned Officer's (NCO's) that are embedded 24/7, within the Operations Communication Centre (OCC) location in Regina. MOSS members are available for consult at times when a supervisor or detachment commander is not working. Staff Sergeant Simons directed the MOSS member to begin the process of calling out additional members and resources.

Upon his arrival on the JSCN, Staff Sergeant Simons met with Constable Maynard and was provided an overview of the events to that point. Staff Sergeant Simons was confident in Constable Maynard's grasp of the situation and left him to continue to coordinate and secure scenes. As calls continued to come in advising of fatalities, Staff Sergeant Simons proceeded to attend scenes as required.

Whether they were aware of it or not, much of the initial response to the JSCN/Weldon event followed the 'principles' that are part of Incident Command System (ICS) that will be explained in further detail in the following section, ***Command Structure***.

Although Constable Maynard was effectively managing the situation, it is worth noting that there are a number of on-line courses that all regular members have access to that offer ***entry level training for management of critical incidents***. This training evolved from recommendations made in the ***MacNeil Report***.

Previous recommendation from MacNeil Report (Moncton 2014):
3.2 It is recommended the RCMP examine how it trains frontline supervisors to exercise command and control during critical incidents.

3.3 The RCMP provide training to better prepare supervisors to manage and supervise throughout a critical incident until a Critical Incident Commander (CIC) assumes command.

Among the available courses are the following:

Initial Critical Incident Response (ICIR) – Level 100 course provides ***regular members*** with the knowledge to effectively take command and control of a critical incident in a logical and methodical fashion, until such time that a Critical Incident Commander (CIC) assumes command.

Initial Critical Incident Response (ICIR) Detachment Tabletop Exercises is a course that was in order to ***better prepare supervisors*** to manage and supervise throughout a critical incident until a Critical Incident Commander (CIC) assumes command. A number of scenarios designed as a table-top exercise are offered for teams to plan out and rehearse when responding to a critical event in a detachment area.

If not already prioritized, ***entry level ICIR training for both junior members and supervisors should continue to be encouraged*** in order to be best prepared for any future critical incidents.

As the situation evolved, victims were being triaged and treated by Emergency Medical Services (EMS) or Community First Responders, while STARS was on scene to transport some of the injured to hospital. The situation was chaotic and some described it as a war zone. As additional RCMP resources were arriving at the JSCN, they were being approached by members of the community (some of which were covered in blood) directing them to additional scenes. Victims' families were attending the scenes, searching for answers and wanting information. Additionally, there were concerns of further violence through retaliation, once the information as to who was allegedly responsible was being disseminated amongst the community.

This 'first wave' of responding RCMP members were forced by circumstance into managing the situation themselves, with MOSS support (explained further below), until more supervisory resources arrived. The tasks of triaging of scenes, the victims, and allocating the resources as they became available were being completed based on the principles of ***command and control*** which is common terminology used to describe the ***majority of policing operations*** in Canada.

Command refers to the ***chain of command*** police agencies organically enter into in order to manage any type of incident from the onset. The principles for command and control are scalable and allow for a similar evolving response from police, should an event expand into a critical incident. Oftentimes these roles and tasking are based on rank, seniority, or experience.

As will be outlined in the section that follows, from the onset of the initial calls for service to the JSCN, to the recognition of it being a larger, more critical event, other command structures were introduced.

Radio Communication:

During highly stressful events such as the circumstances described above, radio communication protocols can tend to erode. Those that responded and were communicating via their portables (when able) or radios in their police vehicles were in large part, utilizing appropriate radio communication. Although it is not known at exactly what point a dedicated encrypted radio channel was identified, ***plain language was being utilized for the most part***. There were some reports of some 10-Codes still being broadcast; however, these instances did not appear to create any gaps in communication. There were no occasions where a gap in communication resulted from poor radio protocol or communication displayed by members.

There can be a tendency for members to avoid using plain language if they are unsure whether their communication is encrypted, to avoid details being broadcast to the general public. Given the fact that the RCMP 10-Codes are readily available in the public domain, the risk especially during this event to using plain language, whether communication was encrypted or not, was minimal. Radio communication will be discussed further in the review of Operational Communications later in this document.

Some members interviewed during the course of the review pointed to the ***Immediate Action Rapid Deployment (IARD) scenario based training*** they had completed as being beneficial during the stressful incidents they were involved in, where clear communication was vital.

Recommendation from MacNeil Report (Moncton 2014):
6.4 It is recommended that IARD training be adapted to include various environments as well as decision making, planning, communication, asset management, and supervision components to ensure members work through constant risk assessments and that OCC training in coordination/response to high risk incidents should be conducted at the same time as IARD training to emphasize the realism of the scenario.

Outside of the language used during this critical incident, it must be identified that ***portable radio reception was very poor on the JSCN.*** There were reports of members having to leave residences every time they wished to transmit over their portable radios. This scenario was described by members as a common issue while on the JSCN. Virtually all members interviewed throughout this review expressed their concern with the poor radio communication on the JSCN.

[redacted] It should be noted that although [redacted] can provide a remedy to poor radio (portable) reception, in reality it only works in a very specific type of scenario and for the most part, is not practical.

Although not as efficient as radio usage, all members that responded to the JSCN were equipped with cell phones that were said to have worked well as a back up to the poor radio coverage. The potable radio coverage issues while on the JSCN will be addressed more in depth later, in the review of ***Operational Communications.***

Recommendation from MacNeil Report (Moncton 2014):
3.1 It is recommended that members be in possession of a cellular phone and police radio while on duty, as a required part of Service order #1.

Equipment and Intervention Options:

A review of the equipment that members had access to, any equipment they were in need of, and after action reporting were topics that were included in the review objectives, and will briefly be outlined. Certainly not all of the over 500 police officers that were called upon for the JSCN/Weldon event were interviewed as part of this review; however, those front line members that had potential to be in the most compromised positions, based on their role, were. The initial responding members and members of the Emergency Response Team (ERT) will be discussed below.

Initially Responding Members:

The two members that initially responded to the JSCN were wearing their working uniform and each were each armed with their loaded service pistol and 2 additional loaded magazines. One member had his Conductive Energy Weapon (CEW) that he was trained to use.

[redacted]
These options travelled with Constable Maynard in his police vehicle when he separated from Constable Miller (as discussed earlier) after discovering the extent of the situation after arrival at the JSCN. [redacted]

[redacted]

[redacted]

Both members had all their intervention options and all were said to be functioning properly.

First Aid Kits were assigned to individual police cars as per policy. Some members had received Basic Trauma Equipment Course (BTEC) training and some (not all) had their Individual First Aid Kits (IFAK) with them. Some members had IFAK's; however, they were left at the detachment and not available. ***There is no guiding policy stating that IFAKs are to be worn on one's duty belt.*** Generally, if a member has the room on their duty belt and chooses to wear an IFAK, they may choose to do so. As a personal issue, IFAK only has a limited amount of supplies in order to keep the physical size of it small enough to wear on a duty belt, there were reports of running out of First Aid supplies (gauze, tensor bandages) while treating some of the victims.

Emergency Response Team (ERT):

The 'F' Division ERT Team is one of a number of units within the 'F' Division Critical Incident Program (CIP). 'F' Division ERT is a tactical unit that are deployed in an attempt to resolve a variety of high risk situations. The Critical Incident Commander is in charge of the ERT teams. The first Critical Incident Commander, Staff Sergeant Steve Bergerman, began making calls immediately after being notified of the situation and, by 7:00 am on September 4th, ERT resources had been secured were initially tasked with saturating the area of the JSCN and searching for the suspects.

Equipment:

[redacted]

[redacted]

[redacted]

[redacted]

After Action Reporting:

The ERT Incident Debrief is a standardized form (Form 1225) that is required to be completed following an incident where ERT is deployed. The form itself has many drop down and 'fill in the blank' style fields and does not call for enough information to articulate a proper response in complex calls. 'F' Division ERT uses a preformatted document to supplement the 1225 for most calls in order to proper document their actions. The difficulties in promoting a standardized form was recognized due mainly to the to the unique nature of ERT calls. The supplement that is attached to the Form 1225 was considered to satisfy reporting requirements.

JSCN Community Interviews:

Following the interviews of the community members from the JSCN, the following information is relevant to this objective:

Response Time:

One of the areas of concern that was raised by the JSCN community members was the time that it took RCMP members to arrive on the JSCN on the morning of September 4th. Naturally, in a situation like the one that evolved that morning, any amount of time spent waiting for police and other emergency services to arrive will be questioned. Not limited to the JSCN community, the public as a whole places a significant amount of value on police response time largely because it creates feelings of security and is believed to be a key factor in crime prevention.

Response time itself, is not necessarily difficult to measure as one can simply determine the time that a call for service was received and the time that it took for police officers to arrive on scene (as will be seen below). Having said that, there are variables that can have an affect on the time that it takes the police to arrive at a scene. As discussed earlier, the Melfort RCMP Detachment has a policing model where a RCMP member is required to be 'on-call' for periods of time where they may be called out from home to respond to a complaint. Further, once a call is received (in this case through a 911 call centre), there may be a period of time between receiving that call and dispatching the police that can affect a response.

Delays from 'on-call':

In the case of the initial response to the JSCN, the following times are known:

Time of the initial 911 call regarding the JSCN:	**5:40 am**
Time the 911 call was ***dispatched*** to Melfort Detachment:	**5:43 am**
Time that members departed Melfort, en route to the JSCN:	**5:52 am**
Time the members ***arrived*** at first scene ([redacted] New York Road):	**6:20 am**
Total time from dispatch to arrival:	**37 minutes.**

It is worth noting at this point that information from the GPS report of the police vehicle that dispatched members were driving indicated they took the route that went straight north from Melfort on Highway 6 (see above map) and speeds varied between 155 km/hr and 178 km/hr, on that main highway. On secondary highways, speeds varied between 115 km/hr and 140 km/hr.

To briefly re-visit the chronology of events that were outlined above, the investigation revealed the following with respect to the ***length of time that the assaults/homicides occurred*** on the morning of September 4th:

- The stabbing of [redacted] is believed to have been the ***first assault*** committed by the suspect. This attack is thought to have occurred ***between 5:30 am and 5:40 am***;
- The ***first homicide*** victim was ***Damien Sanderson***, which was thought to have occurred after he and the suspect departed [redacted] residence ***around 5:40 am***;
- The ***last homicide*** victim was [redacted] that was believed to have occurred at approximately ***7:10 am***;
- Based on these times, the ***suspect's spree of violent attacks lasted for approximately 1 hour and 40 minutes***.

As set out above, there are regular periods of on-call at the Melfort Detachment where a member is not required to be physically present at the detachment. On the morning of September 4th, however, Constable Maynard was already at the detachment for an unrelated occurrence when the initial 911 call to the JSCN was dispatched. The only 'delay' in the response time from the Melfort RCMP was the time that it took Constable Maynard's backup (Constable Miller) to arrive at the detachment once he was called from his home to assist. There is no question that Constable Maynard followed policy by

ensuring he had back-up to respond to this complaint. ***RCMP Policy dictates that back up was required due to the nature of the call.*** Proceeding to this call without waiting for back up was not an option, nor was it considered. Once Constable Miller arrived at the detachment, both members departed immediately for the JSCN.

The time that it took Constable Miller to arrive at the detachment was reasonable. The decision by Constable Maynard to wait for his backup to arrive at the detachment and board into his waiting police vehicle so they could depart together ***did not create any unreasonable delay*** in their response.

Delays from 911 dispatch:

As discussed earlier, 911 calls in Saskatchewan are received by PSAP's in Regina, Saskatoon, and Prince Albert. In the case of the JSCN/Weldon event, ***the initial and subsequent 911 calls were forwarded from Prince Albert to the RCMP OCC, in Regina.*** From that point, the Melfort RCMP Detachment was dispatched.

During the review, there was ***no indication of competing 911 calls*** at the time of the initial call related to the JSCN on the morning of September 4th. It was not until after the initial call, that an influx of additional 911 calls were received. ***The entire dispatch process for the initial 911 call took very little time and could not have been streamlined more than it already was.***

The 911 calls related to the JSCN/Weldon event will be further discussed in the ***Operational Communications*** section of the review.

Given the above context under which the RCMP were initially dispatched to the JSCN, combined with the distance required to travel, ***their response time was appropriate.***

RCMP Visibility:

Overall, the communities of both the JSCN and Weldon were appreciative of the efforts of all resources that responded to the events on September 4th. During these discussions, however, community members naturally led into conversations about overall RCMP visibility, specifically on the JSCN.

Similar to police response time, police visibility in the communities they serve can entice those same feelings of security and is largely believed to contribute to overall crime prevention. When the public sees the police conducting patrols (either in a vehicle or on foot) of a neighborhood or town, there is naturally an increased awareness amongst

citizens that their community matters. This notion is widely accepted and is not limited to the JSCN community alone.

A number of the JSCN community members held the belief that if there had been a member posted directly on the JSCN at the time of the offence, that there would have been fewer victims. This again, is a natural response following such a horrific event; however, that type of service delivery model was not an option and goes beyond the scope of this review, which is to evaluate the RCMP response. Nonetheless, the amount of community members that raised concerns over the lack of visibility (and familiarity) of the RCMP at the JSCN warrants it being addressed in this section.

After conducting interviews with JSCN community members, it became apparent that there are mixed opinion as to the overall relationship between the Melfort RCMP and the JSCN.

During the response to the events on September 4th and the days that followed, there were countless numbers of RCMP members in and around the community of JSCN. In acknowledging their appreciation for this response, some questioned why, aside from the Detachment Commander, the Melfort Detachment members did not respond. Since ***every available member from the Melfort Detachment responded to the JSCN***, this perception may speak to the lack of familiarity of the Melfort Detachment members amongst community members.

The Melfort Detachment does have a dedicated ***Community Tripartite Agreement (CTA)*** in place with the JSCN. Under CTA arrangements, a First Nation or Inuit community has dedicated officers from an existing police service, usually the RCMP. As some community members pointed out, historically some of these dedicated members have 'clicked' and some have not. The member that holds that dedicated Indigenous position within the Melfort RCMP is an Indigenous member that was said to commit a large part of his time and duties to his responsibilities on the JSCN. He was spoken very highly of and was praised for his efforts in the community. As such, the JSCN community has embraced him. This member was not working during the events surrounding September 4th, but it highlights the need to have more networking amongst all detachment members, not only those that hold that one specific job description.

The overall sentiment from the JSCN community was that the RCMP should make efforts to be more visible within the community and to encourage more (and better) communication with the JSCN, not only during planned community events when they are

asked to participate, but in general. While increased public confidence may be a result of these efforts, community engagement is perhaps the most crucial component that can have any lasting effect on crime reduction in the community.

Recommendation 1.2 – The Detachment Commander should encourage other members to attend the JSCN, whether on patrol or for events in order to create relationships with the community.

Areas of Effectiveness:

Overall Response of the RCMP:

Much of the response of the RCMP to the JSCN and Weldon revolved around the mass casualty response and victim care that will be highlighted more in the ***Mass Casualty/Victim Response*** section of this review. It should be noted that the overall response to the JSCN by the RCMP was recognized and appreciated.

There was a lasting impression amongst community members that the 'authority' of the RCMP did not prevail in their communication with the community during the incident. Instead, 'respect' and 'kindness' were words that were used to describe communication with the JSCN by the RCMP in their response. RCMP members were viewed as being very approachable, which led to some level of reassurance, during the incident. Having Indigenous RCMP members deployed was identified as beneficial and would have been even more so, had they spoken the community's language.

Initial Triage of various scenes and victims:

It will be mentioned throughout this review, that the circumstances surrounding this event were something that the vast majority of the police officers will never be confronted with during the course of their careers. The scenes that the initial responding members arrived at and the responsibilities and decisions that had to be made in relation to all the victims, would have easily overwhelmed most.

The actions taken, by both the initial responding members and the community members, were commendable. Both prior to and during the RCMP arrival on the morning of September 4th, those from the JSCN (both community members and family) had to deal first hand with the aftermath of what had occurred. Timely and critical decisions had to be made under unthinkable circumstances. Although the ***Command Structure*** of the overall event will be discussed in the following section, it is worth noting that at the stage of the first response, the command displayed by those involved during these moments was notable.

First responders were required to make decisions on a number of fronts, such the initial scene assessments, triaging victims, dealing with the growing numbers of scenes and victims, directing the movement of victims to collection points, providing first aid, and potential suspect apprehension. All of these decisions were made while a growing number of resources arrived on scene requiring direction, as a suspect(s) who had just murdered a large number of people and was continually changing vehicles, was still at large.

In a mass casualty event such as this, the actions taken by those arriving first on scene can often mean the difference between a poorly run scene that may put both the victims and the overall investigation at risk, and a well run scene that offers those same aspects the best chances of survival. Those members that took over command of the incident commented numerous times about how they were better able to transition, due to the leadership displayed by the initial responding members.

The speed in which the Emergency Operations Centre (EOC) was set up at the JSCN by community members; to the communication between Band members and the RCMP in order to direct RCMP members to the various scenes and victims; to the decisions that were made surrounding who would take charge of triaging those scenes and victims, all contributed to an overall sense of organization in an otherwise incredibly chaotic situation.

Command Structure

At any point in time, regardless of the type of situation that the RCMP is responding to, there is a command structure in place that outlines various roles and responsibilities for those involved. If a member is responding to a complaint that is less critical in nature, the command structure may remain at the detachment level with those members at the scene or those in a supervisory role within their own detachment. As a situation becomes more critical and complex, command may move beyond the detachment, to a district and potentially a divisional level. Once at a divisional level, national interests and oversight are commonplace. When situations advance from one level to another, changes arise in the command structures responsible for providing direction in order to meet identified objective(s).

The vast majority of law enforcement incidents begin and end locally and are managed on a daily basis at the lowest possible geographical, organizational, and jurisdictional level. In approximately 95% of all incidents, the organizational structure for Operations consists of command and single resources. Very seldom is there a requirement to 'scale up' and activate any higher level management of an event. The RCMP is well practiced in terms of managing these singular events or investigations where recognized command structures are pre-established.

In some cases, however, command will still be local, but it will require special command protocols and resources. Consider the following two higher level critical incident examples:

A Homicide - When a homicide occurs, the local detachment members are the first to respond and the Major Crimes Unit (MCU) is called. Upon arrival at the location, MCU takes command and utilizes the principles of Major Case Management (MCM) to direct resources. A Command Triangle (CT) consisting of a Team Commander, a Primary Investigator, and a File Coordinator act as the reporting structure for the entire investigative team. In many cases, the suspect(s) is quickly identified and apprehended by the investigative resources in relatively short order. The highest level of command in an event of this nature does not go beyond the CT.

An Armed and Barricaded Subject - In this scenario, where the suspect(s) poses substantial risk, but is contained to an area, the Critical Incident Program (explained later in this section) is engaged, and a Critical Incident Commander takes overall command of the incident. Notwithstanding the criminal investigation being investigated at a local level, the Critical Incident Commander remains in charge until such time that the subject is taken into custody. Again, in many cases, the suspect(s) in these instances is quickly identified

and apprehended in relatively short order. These incidents, although serious, occur frequently and they do not require resources beyond the local detachment and the capacity of the Critical Incident Program (CIP).

In these two examples, it is well established that all resources will report to a local Detachment supervisor, the Detachment Commander, the MCU Team Commander, or the CIP Critical Incident Commander, as the case may be. With this said, and despite that the vast majority of incidents are dealt with at the local level, the RCMP is experiencing more and more incidents where critical incidents are going beyond the capacity of our traditional command structures. Suspects are more mobile; they have access to assault-style firearms; they are digitally connected with other suspects; and they have access to smart phone technologies, making police responses to these increasingly higher risk situations more challenging. These events, especially where containment cannot be quickly established, can rapidly expand into multidisciplinary, multi-jurisdictional events, that require significant additional resources and operational support. When these situations occur, they can overwhelm our localized or traditional command structures. Where most critical incidents will require less than 20 or 30 resources, some events are now evolving to situations that might require hundreds of resources, i.e the 2020 Nova Scotia mass casualty event or the 2014 killings of 4 RCMP members in Moncton.

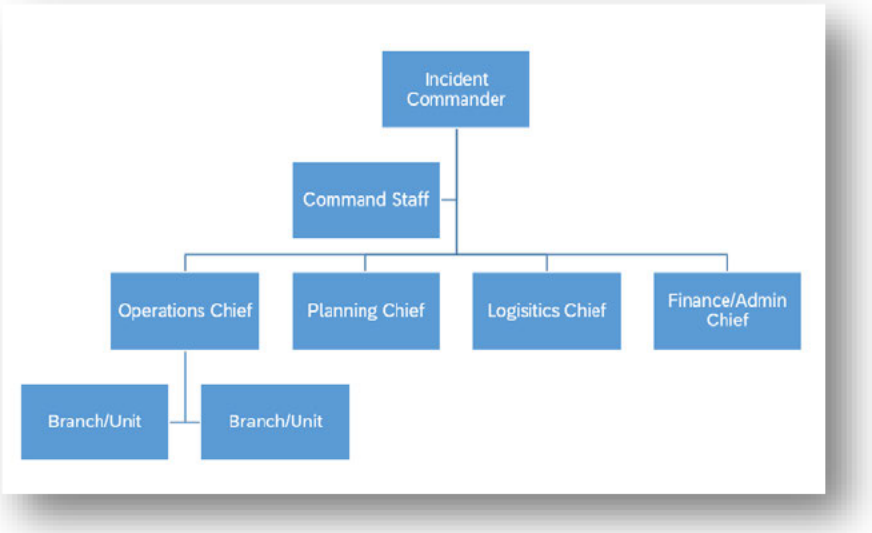
The JSCN/Weldon event was a situation that evolved into a divisional response almost immediately. The police response was comprised of a number of different elements and required assistance from various units, divisions, and police forces. Instances of this nature require effective and efficient coordination of resources across the spectrum of organizations and activities that responded. These types of incidents are occurring more frequently due to the dynamic environments that police agencies operate in, where seemingly routine calls for service become complex critical incidents in a matter of moments. This shift has forced the RCMP to re-visit our responses to these critical incidents; however, there is an ***absence of nationally recognized policy or procedure for RCMP*** response to events of this magnitude. With that said, there is divisional policy in Alberta (K) and British Columbia (E) that outline the use of the ***Gold / Silver / Bronze structure in conjunction with Incident Command System*** for major police incidents or events. Although this divisional policy offers some clarity to articulating major events, there remains some uncertainty surrounding the interrelationships between the two systems, and again, there is not yet a National standard in place.

A brief description of the two widely utilized command structures is warranted to offer clarity to this section of the report.

Incident Command System Overview:

The Incident Command System (ICS) is a model for command, control, and coordination of emergency response at an emergency site. It provides a way of coordinating the efforts of agencies and resources as they work together toward safely responding, controlling and mitigating an emergency incident. Although originally designed in response to wildfires in the 1970's, ICS has evolved into an all-hazards system that is appropriate for all types of all types of incidents, including those involving multiple casualties that required a multiple agency response.

The ICS organization is built around the five major management functions of Command, Operations, Planning, Logistics, and Finance/Admin:



ICS Organizational Chart

The ***Command*** function is directed by the ***Incident Commander***, who is the person in charge at the incident and who must be fully qualified to manage the response. ***The role of IC is initially taken by the first responder to arrive at the scene***. He or she is responsible for managing all tactical resources and overseeing ***Operations***. In approximately 95% of all incidents, the organizational structure for Operations consists of command and single resources. Very seldom is there a requirement to 'scale up' and

activate the ***Planning***, ***Logistics***, and/or ***Finance/Admin*** sections as they are ***management elements*** and have less to do with the tactical response.

When utilized, the ***Planning*** section maintains status of resources and prepares other incident-related documentation. The ***Logistics*** staff provides services and support to meet the incident or event's needs such as acquiring necessary resources and other services. ***Finance/Administration*** staff monitors costs and keeps track of incident-related expenses such.

GSB Overview:

The GSB framework provides a structure for delivering a strategic, operational, and tactical response to a spontaneous incident or a planned operation. It also allows processes to be established that facilitate the flow of information, and ensures that decisions are communicated effectively and documented as part of an audit trail.

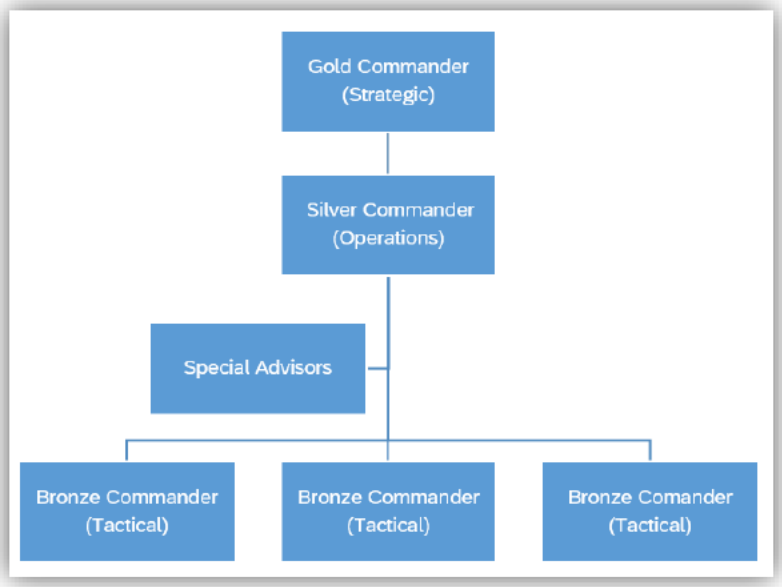
Most incidents and operations are resolved by using a simple GSB command structure, with the responsibilities and accountabilities of each commander clearly set out in command protocols. The command structure is role, not rank, specific and allows for flexibility.

The ***Gold commander*** is in overall control of their organisation's resources at the incident. This person will not necessarily be on site, but at a distant control room where they will ***formulate and oversee the strategy*** for dealing with the incident.

The ***Silver commander*** is the ***operational commander*** who manages operational implementation following the strategic direction given by Gold, and makes it into sets of actions that are completed by Bronze. Whether the Silver commander is present at the scene can vary by incident and agency.

A ***Bronze commander*** is responsible for the command of a group of resources and carrying out functional or geographical responsibilities related to the tactical plan.

If an incident is widespread geographically, different bronze commanders may assume responsibility for different locations.



GSB Command Structure

The established structures of ICS and GSB have been debated for some time, and continue to be. The two command systems are utilized due mainly to the built in flexibility allowing response organizations (police, emergency services, etc.) to utilize only those aspects that are practically suited to a given incident. Both models promote adaptability without jeopardizing clear lines of communication or accountability. Regardless of the model an organization observes, the inherent processes and methodologies should be the focal point, not the model itself.

JSCN/Weldon Event – Methodological Challenges:

As will be seen there are several aspects to 'Command' that can be explored when attempting to determine the overall effectiveness of response. This was by far the most challenging section of the report to review and document due, in part, to the absence of any organizational chart spelling out the various roles and responsibilities for those managing the overall event. Adding to the complexity of the review was the aforementioned reality that no firm national policy exists, from which to form a proper assessment.

Throughout this report there will be references being made to a variety of command terms, such as 'Incident Commander'. Although these terms may refer back to the specific elements of either ICS or GSB (or both), this is not to say that the 'F' Division RCMP directed their response solely based off one model, or the other. Specific terminology is

used because, either those members interviewed referred to it themselves or the review team observed a particular command role/term.

A number of ***Organizational Charts (Org Charts)*** are included throughout this section. These Org Charts were not provided to the review but rather generated by the Review Team as a means to offer clarity to the evolving command structures that were unfolding as the JSCN/Weldon event evolved.

There will be ample discussion surrounding command posts throughout this section. It is widely accepted, regardless of philosophy, that only a ***single Incident Command Post*** should be utilized for critical incidents as this is the location from which the ***Incident Commander (IC)*** oversees ***all operations***. Under 'normal' circumstances the IC role would be assumed by the ***Critical Incident Commander (CIC)*** (explained further below), as the vast majority of incidents do not require any command function above the level of the CIC. As will be noted throughout this section, the JSCN/Weldon event quickly outgrew the capacity for the CIC on-site to manage the entire event, and an overall IC became engaged. The CIC and IC ultimately had separate roles in this event and with that, came the utilization of two command posts, one functioning as the overall ***Incident Command Post*** and the other as the ***tactical command post*** that was responsible for apprehension efforts being made. The evolution of the two command posts will be further explained later in this section, but a general awareness of their unique functions at this point will assist in recognizing the occasional lack of clarity as to who was in command in specific instances over the course of the three days.

Command Interface:

Immediately following the initial call for service and the attendance of the first responding members, the Critical Incident Program was activated and a CIC was mobilized and would eventually assume command, on-site by mid-morning on September 4th, for the majority of the event. Also during this time, senior management were working out of the Division Emergency Operations Centre (DEOC) that was in the early stages of activation to assist with event logistics, fulsome briefings, and upper management reporting. The DEOC was being staffed to the extent that arrangements were being made to enter into a shift schedule to manage the likelihood of having more than one operational period. The Major Crimes Unit (MCU) were activated and after determining the scope what was unfolding, developed a number of 'sub-teams' out of necessity who, in turn, reported to the Team Commander of MCU.

The activation of these various levels of command in such a short period of time illustrated the earlier point of how police are generally proficient in operating within a more localized organizational structure; however, when a situation evolves past that level is where lines of command can become less clear.

Emerging Reporting Lines:

In the hours and days leading to the arrest of the suspect, reporting lines were developing whereby, those tactical units on site (MCU, CIC, FIS, etc.) reported up to the DEOC where the eventual Incident Commander and DEOC Commander were positioned.

Although the various functions were sufficiently utilized for the duration of the event, ***there were elements of the command model that would have benefitted from a more structured approach.*** This emergent reporting structure, although not outlined at the time of the event, may have contributed to some of the ambiguity as to who was in 'overall command' at various points in time.

Command of the JSCN/Weldon Event:

Despite the fact that very little of what took place throughout the course of the JSCN/Weldon event occurred in a linear fashion, with clearly defined start and end times for the various levels of command, a sequential review of the various command roles that evolved became the most logical review format to consider. As will be seen, the activation of a certain command functions did not happen in isolation as there were multiple duties being prepared for at any given time that led to various groups and tasking's specific to certain command elements being assigned.

When the incident grew to a divisional level response, the primary command functions for the JSCN/Weldon event largely revolved around the ***Critical Incident Commander*** and those managers that were working out of the ***DEOC***; thus, those two functions will encompass the majority of this section. Additionally, the response by the 'F' Division ***Member Operational Support Services Unit (in conjunction with the initial responding members) and the Criminal Operations Duty Officer, and the Major Crimes Unit (MCU)*** will be focal points of review. The actions taken by the ***initial responding members*** were discussed at length in the previous section and will only be expanded upon when necessary, from this point onward.

The original intent was to evaluate each command portion as a separate objective; however, as the review of this section progressed, documenting each role in isolation did little to promote clarity for the reader. It is well-documented that various levels of command had substantial interaction and sometimes became inter-twined; thus, documentation of specific command roles do not simply begin and end within the sub-headings below but rather, will be noted throughout the entire section, when relevant.

Member Operational Support Services (MOSS) Unit:

Structure and Function:

MOSS Units are located in many divisions of the RCMP and are staffed with full time, senior non-commissioned (Sergeant or higher rank), regular members. Part of their job function is to ***review all priority calls to the Division Operations Communication Centre (OCC)***, via the Computer Integrated Information and Dispatch System (CIIDS) computer system. This enables MOSS members to monitor files as they are received into the OCC, so they can become engaged early on, if situations evolve.

MOSS members are available for consult at times when a supervisor or detachment commander is not working. Normally, calls to a non-working supervisor or detachment commander will only be made in the most serious of situations or on the advice of the MOSS member. ***This was the scenario that presented itself on September 4th when the detachment commander of Melfort was notified by the MOSS Unit following the initial call(s) for service.***

The MOSS Unit can provide varying degrees of assistance or guidance to a front line member, depending upon the presented situation. Essentially, any operational uncertainty that a front line member is confronted with can be forwarded to a MOSS member for advise on how to proceed or react. Geographically, the MOSS Unit is located in Regina RCMP Headquarters and is embedded in the OCC. Members can access MOSS through the OCC, thus the assistance that MOSS Units offer can occur in 'real time', when required. In some RCMP Divisions there is an appetite to evolve the MOSS program further, to a Real Time Operations Centre (RTOC) that is a more team-based approach to providing command and/or operational support. For the purpose of this review, only the MOSS Unit will be discussed.

A full time MOSS Unit was created in 'F' Division, in part due to the following recommendation made by the ***MacNeil Report 2014***, as previously referenced.

Recommendation from the MacNeil Report (Moncton 2014): 7.10 Operational Communications Centres (OCCs) should have an experienced non-commissioned officer (NCO) available to coordinate operations in critical incidents and to offer direct operational advice to call takers and dispatchers.

The 'F' Division MOSS Unit mandate is to provide the most current information and policy to support members in the performance of their duties and to be available as a contact point between the public and the police.

Initial Command:

MOSS Unit / Initial Responding Members:

As outlined in the previous section, Constable Maynard was dispatched by the OCC to a call of a stabbing on the JSCN at approximately 5:44 am on September 4th. During this time, there was a MOSS member on duty in the OCC who was aware of the initial call.

Although urgent in nature, there was nothing to suggest that this complaint differed from others of a similar nature that had been received in the past and there was no information at this time to suggest that a more serious incident was unfolding. When another call came in minutes later, the MOSS member contacted the responding members and there was discussion surrounding whether the two calls were related. Constables Maynard and Miller had yet to arrive at the JSCN to determine exactly what was happening and were unsure at this time if the calls were associated. At approximately 6:11 am, additional calls came in to the OCC and it became ***clear at this point that there were multiple victims***. Constables Maynard and Miller were driving to JSCN at the time of these updates and from this point onward, maintained consistent communication with MOSS member and worked in concert to command the unfolding event, at that time. The MOSS member made immediate calls to Staff Sergeant Simons and to the on-call ***Duty Officer*** (explained below) to make them aware of what was transpiring. By 6:47 am the on-call ***Critical Incident Commander (CIC)*** had been notified. Despite these notifications, ***command of the incident remained the responsibility of the initial responding members (with oversight from the MOSS Unit)*** as they had the most situational awareness at that time.

By 7:00 am, there was a shift change and incoming MOSS member(s) continued the process of calling other members or units out to assist at the JSCN. MOSS members have 'back line' contact numbers for partner agencies and were able to reach partner agencies such as the Regina Police Service (RPS) quickly. The value of this direct contact information was demonstrated at the time that information was received identifying a suspect. A Correctional Service employee responsible for the suspect was able to be contacted in short order. Police Dog Services (PDS), Major Crimes Unit (MCU), Forensic Identification Services (FIS), and all other requested units were contacted by the MOSS Unit and were being deployed. The MOSS member who took the initial call continued his duties and stayed on shift until later in the morning to assist with tasks in the ***DEOC (explained later), which was also in the process of being activated at this point***.

The size and scope of the unfolding event at the JSCN/Weldon resulted in ***effective event recognition*** by the MOSS Unit members in conjunction with members at the scene. This

recognition allowed them to ***scale up very quickly*** and obtain as many resources to bear as possible.

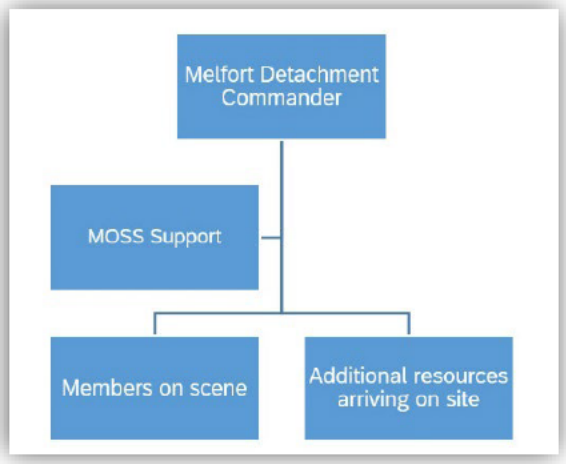
Effective Practice:
Have a list of back line numbers for various agencies and units to facilitate direct contact, especially during the early morning hours when most are not working or at their regular contact numbers.

Staff Sergeant Simons became the defacto ***Incident Commander*** upon his arrival on JSCN at 7:38 am, ***with support from the MOSS Unit.*** At this point in time, higher level command functions were being arranged; however, the members on-site were in command as they had all of the situational awareness and were directing whatever resources they had available to them. ***First responding members recognized this and understood that Staff Sergeant Simons was in charge upon his arrival at the scene.***

Staff Sergeant Simons had received training in Incident Command Systems (ICS) and Initial Critical Incident Response (ICIR) which is training that stemmed from recommendations of the ***MacNeil Report*** (mentioned previously). Admittedly, however, Staff Sergeant Simons stated that no amount of training could properly prepare someone for what he and his members responded to on the morning of September 4th.

Staff Sergeant Simons ultimately allowed Constable Maynard to continue with triaging victims, scenes, and directing additional resources that were arriving. This was a mindful decision as Staff Sergeant Simons had only been the detachment commander in Melfort for 6 weeks prior to this incident and in his estimation, Constable Maynard was more than capable of continuing the coordination of scenes.

Due to the complexity of the incident and the timeliness required to manage the situation, it would have been counter-productive for Staff Sergeant Simons to take on those duties based solely off his rank. Staff Sergeant Simons assisted with scenes and victims as was necessary, all the while liaising with MOSS members, the DEOC (once activated), and the OCC in an attempt to have more resources deployed to the JSCN to assist.



Initial Org Chart – Detachment/MOSS

Duty Officer and Criminal Operations Officer involvement:

As previously mentioned, the MOSS member promptly notified Inspector Murray Chamberlin (Inspector Chamberlin) who was the ***on-call Duty Officer*** (Duty Officer) on September 4th. For clarification, a Duty Officer is an assigned Commissioned Officer that receives higher level notifications or updates of unfolding events that are of Divisional interest. A Duty Officer is on-call during times when the District Officers and District Management Teams are not working, to have oversight and ensure that senior management is aware of any critical unfolding events.

Effective Practice:
'F' Division maintains an on-call Duty Officer program, where Commissioned Officers are rotated through a schedule to cover any significant issues or incidents. 'F' Division maintains a Duty Officer matrix used by the MOSS Unit that outlines threshold for when notification is necessary.

At the time, Inspector Chamberlin (Duty Officer) also held the role of the North District Officer. Inspector Chamberlin was essentially assuming two levels of notification simultaneously; the Duty Officer and the (acting) North District Officer.

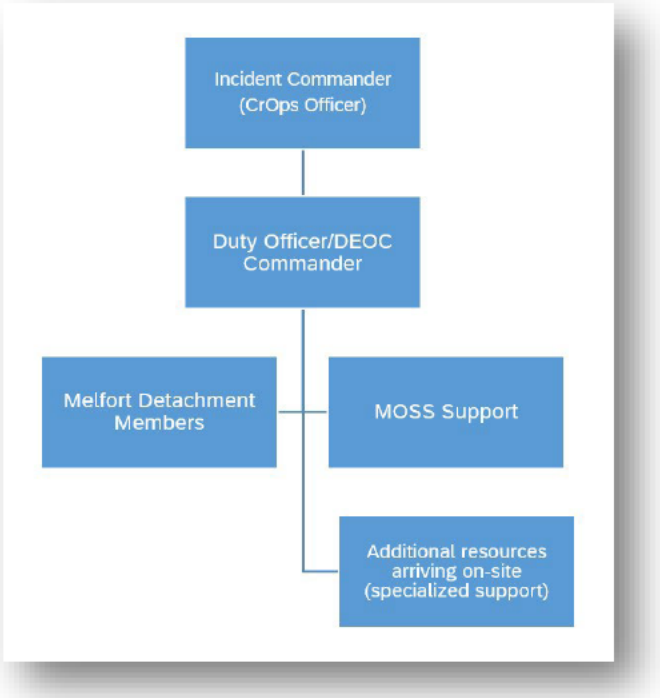
In his role as the Duty Officer, Inspector Chamberlin immediately notified the CrOps Officer, Chief Superintendent Teddy Munro (Chief Superintendent Munro) of the unfolding event. During their initial conversations, specifically at 8:32 am, the ***decision to activate***

the DEOC was made. It was decided that Inspector Chamberlin would manage the ***DEOC*** out of Regina HQ (discussed next) and Chief Superintendent Munro would travel back from holidays first to Prince Albert, to ensure that the North District Management Team (DMT) was running effectively, then to Regina to assume his duties as CrOps Officer out of HQ. Other ***key senior personnel from the Division were also directed to the DEOC*** where most remained for the duration of the event.

When Inspector Chamberlin had a conversation with Chief Superintendent Munro and the decision to activate the DEOC was made, Inspector Chamberlin's ***role of Duty Officer essentially ended*** and he transferred to the role of managing the DEOC. Although no specific designation was discussed, Inspector Chamberlin effectively became the ***DEOC Commander***. No matter the role he was in, Inspector Chamberlin and Chief Superintendent Munro remained closely aligned for the duration of the JSCN/Weldon event.

As will be pointed out later in the Strategic Communications Section, Inspector Chamberlin approved the initial release of the Public Alert in his role as the Duty Officer; however, operational guidance was not issued from that role. In essence, the role of the Duty Officer was relatively short in duration.

At the time the Duty Officer notified the CrOps Officer of what was unfolding, by 8:32 am, the ***CrOps Officer had assumed overall command*** of the event and shouldered the ultimate responsibility and accountability for the RCMP response; however, any ***tactical direction*** in relation to the evolving event and on-site resource allocation ***remained with those initial responding members and any specialized units at the scene, with support from MOSS.*** Although not formalized, the following chart appeared to be the structure that was evolving.



Expanding Org Chart – Duty Officer/CrOps Officer

At this stage, there had yet to be an identified Incident Command Post. Although the DEOC was being activated for assisting with resources, the Critical Incident Commander (described below) had yet to arrive on-site to establish any type of base from which to oversee the entire operation.

The event, as it unfolded, was very dynamic and urgent in terms of the requirement to scale up the response from the first members attending out of Melfort Detachment. The MOSS Unit's initial deployment of resources combined with the Duty Officer and CrOps Officer's ***recognition of the expanding incident*** and the need for higher level strategic and longer-term decision making which constituted the ***activation of the DEOC***, met this initial requirement.

Division Emergency Operations Centre (DEOC):

Organization and Primary Function:

All RCMP divisions have a DEOC facility that only functions in the most emergent situations and is not activated for the vast majority of critical incidents. In the case of the JSCN/Weldon event, the main role of the DEOC was arranging for resources in support of

the CIC mission. Similar to an Emergency Operations Centre (EOC) that may be established for a non-police led responses such as a wildfires or floods, the DEOC is essentially the RCMP equivalent. The DEOC itself is ***not a designated command function***.

That being said, the DEOC inevitably became the space where senior management chose to assemble and perform their duties such as fulfilling higher level reporting, communicating and liaising with provincial/municipal government and the Federation of Sovereign Indigenous Nations (FSIN) representatives, and holding the highest level briefings. The DEOC was also the space where, at times, the most up to the minute information was being received as there was a conduit to the Operational Communications Centre (explained later) and further, all deployed resources were reporting to the DEOC Commander (Inspector Chamberlin) and CrOps Officer (Chief Superintendent Munro), situated in the DEOC. It could be argued that those in the DEOC had the highest level of overall situational awareness at any given time, which eventually gave rise to moments where tactical direction was being relayed from the DEOC. In order to pre-empt these types of situations, Inspector Chamberlin had pointed discussions with the MCU Team Commander and the CIC early on, to clearly affirm the DEOC's support role. Despite Inspector Chamberlin's efforts, the lines between support and command became blurred at times. This was the rationale for including DEOC in the Command section of this report.

DEOC Organization:

The structural organization of the DEOC resembles that of the ICS structure and, when activated to its capacity, features ***Operations, Planning, Logistics,*** and ***Finance/Administration*** sections. The Logistics, Planning, and Finance components are built from the top down beneath the respective section chiefs in order to manage the event or incident. In contrast, the Operations Section is built from the bottom up as more operational resources converge at the incident site. As operational resources increase, supervision may need to be expand and the section develops accordingly.

In relation to the JSCN/Weldon event, not all of the DEOC sections were utilized, nor were they required. Given the urgent requirement for resources, the ***Logistics*** section was staffed almost immediately (as will be seen below).

Effective Practice: Although not all roles were utilized, planning for these roles within the DEOC were considered as required. For future events, exploring call-out system options, generating a 'call out list' of division employees who can fill the various roles, and/or supporting appropriate training would continue to support efficiency of staffing this resource requirement.

Following DEOC activation, Sergeant Conrad Logan (Sergeant Logan) was assigned to Logistics (Logistics Chief) and he briefed with Melfort Detachment members to acquire information about the situation and to gain an understanding of how many resources were required. As such, the DEOC requested 60 resources for the various scenes being identified at the JSCN from contacts in 'D' Division (Manitoba) and 'K' Division (Alberta). The process by which outside division resources were obtained was efficient. This was in part, based off Sergeant Logan's extensive service and having inter-divisional partners in his contact lists. This allowed for resource requests being fulfilled in an efficient manner. Requests were made directly for additional members and divisions quickly facilitated those requests.

Not unlike a regular member being called out for back-up, support services and sections such as the FIS, MCU, and ERT maintain an on-call schedule for their employees. When a detachment or unit requires specialized support, they can have these units activated to attend their jurisdiction to bring additional expertise to help resolve a situation or an event. All required support sections were notified and dispatched to the incident as per routine call out procedures common to all units on-call in the Division. Required sections were called out and deployed appropriately. In the end, some ***549 RCMP resources were deployed*** to assist with the JSCN/Weldon event from various divisions, business lines, and units across the country.

Although not part of the initial response, local municipal services were requested, utilized, and updated accordingly by the DEOC throughout the event. Regina Police Service (RPS), in particular, was in constant communication with the DEOC and had a liaison embedded in the DEOC, evaluating all intelligence received through RPS assets. This process ensured that only viable information would be forwarded to the CIC at the time when the suspect was believed to have been in Regina (explained later).

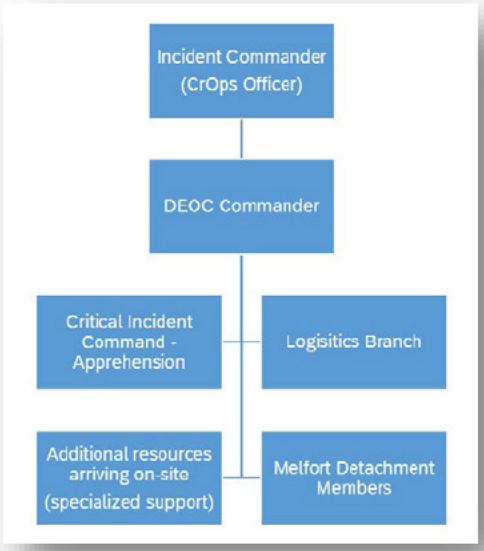
The 'F' Division DEOC had a manager that worked to organize materials with the ultimate goal of updating DEOC procedure. This remains an on-going process. Part of this procedure was the planning of 'table top' exercises designed to practice DEOC activation. In response, some 50 members of the 'F' Division Senior Management Team (SMT) performed a practice exercise that required DEOC coordination in response to a major event, 3 weeks prior to the JSCN incident. This exercise clearly bolstered the establishment and organization of the DEOC in this incident. Further, experience with previous major events within 'F' Division assisted the SMT in recognizing the extent of what was required in this instance.

As will be noted later in the Operational Communications section of this report, OCC operators (dispatchers and call takers) would also benefit from being part of any table top exercises or training scenarios that are being run by the DEOC or otherwise.

For the vast majority of the event those in the ***DEOC served well in their primary support function***.

Evolving Event:

Once the DEOC was activated the coordination and consultation of the various agencies, units, and multiple commanders was carried out from that location for the duration of the event. By 1:00 pm on September 4th, senior management held their first fulsome briefing in the DEOC.



Expanding Org Chart – DEOC activation

Meanwhile, a Critical Incident Commander had arrived on scene and had taken command of the tactical (apprehension) component of the event. The Major Crimes Unit was in the process of coordinating scene management, the criminal investigation, suspect apprehension, and victim management. The arrival of all these units and resources in short order, and in relatively the same period of time naturally resulted in reporting lines being somewhat obscured at times.

Evolution of the ICP - DEOC:

As will be discussed below, in the Critical Incident Command section, the Incident Command Post (ICP) is widely recognized as the location from which the Critical Incident Commander (CIC) oversees all incident operations. This notion holds true in the majority of policing situations where a CIC is directing of all aspects of the critical incident, on-site. This was not the case in the JSCN/Weldon event; however, where the capacity for CIC to manage the entire event had reached its limit and the ***ERT CP*** (explained later) eventually gave way to the DEOC as being the location for the overarching ***Incident Command Post***, for the majority of the event.

Considering that much of the upper management in 'F' Division worked from HQ in Regina, the DEOC naturally became the base from which they performed their duties for the JSCN/Weldon event. Bearing this in mind, once the DEOC had been activated and those senior managers were working from that location and were taking on certain command responsibilities, it did not diminish their understanding that the ***CIC was in command of the tactical (apprehension) portion of the operation***. The question of who was in command was reportedly clear at the senior management level as the ***criminal investigation*** was being led by the ***Major Crimes Unit*** with ***CIC*** commanding of all ***tactical decisions*** on the ground. Meanwhile, the ***DEOC was continuing the process of acquiring a number of resources*** that were being staged out the District Management building in Prince Albert. Ultimately, both the DEOC and CIC were reporting up to the CrOps Officer who was then, in effect, the ***Incident Commander*** and directed the ***strategic component*** of the police response. Although, there was no report of this designation ever being rendered upon the CrOps Officer, when considering the command philosophies discussed earlier, the title is appropriate to what occurred.

Critical Incident Command:

Background and Policy:

A Critical Incident Commander (CIC) is a Commissioned Officer or Senior Non-Commissioned Officer (NCO) who has successfully completed the Canadian Police College (CPC) Critical Incident Commanders Course (CMDNR). His/her role is to command, coordinate, and manage all resources in response to a critical incident. A ***critical incident*** is defined as an event or series of events which by their scope and nature require a ***specialized and coordinated tactical response***.

Upon being deployed to a critical incident, the CIC is responsible for:

- Command and control of the incident and all related resources;

- Ensuring that liaison is established and intelligence shared with support units;
- Assessing the situation, requesting required resources, assuming overall command, and unless exigent circumstances exist, attending the scene;
- Assessing containment and evacuation efforts;
- Establishing a command post;
- Ensuring decisions are recorded by a scribe;
- Authorizing negotiations;
- Approving operational plans;
- Conducting appropriate briefings and debriefings;
- Approving the release of information to the media;
- Ensuring effective transition of command; and
- Timely relief of the critical incident personnel.

The Officer in Charge of Provincial Support Services (Inspector Devin Pugh) is responsible for the ***Critical Incident Program (CIP)*** within 'F' Division. The CIP itself is a group of support service units that are formed to respond to critical incidents. The CIP may be formed from a number of Provincial and Federal Support Units which includes but is not limited to:

- Air Services;
- Critical Incident Command;
- Containment Team;
- Special I;
- Scribes;
- Crisis Negotiation Team (CNT);
- Command Post Staff;
- Radio Operators; and
- Emergency Response Team (ERT).

In accordance with the Critical Incident Program, the ***Critical Incident Commander is trained to have overall command and control of the critical incident*****,** until such time that it is no longer deemed a critical incident, or that person is relieved by another Critical Incident Commander, who assumes command. This procedure generally holds true for most critical incidents where, as pointed out earlier, the bulk of which are managed with the existing resources that are a part of the CIP, such as ERT and CNT. In these types of

deployments, only the support units deemed necessary will respond, and most incidents are resolved with these specialized resources, at the lowest level.

That being said, as the RCMP experience more of these types of incidents that transition to into major events where multiple resources are required (local, divisional, and national), there is a recognition that the CIC may no longer have the capacity to maintain 'overall command'. This was the case with the JSCN/Weldon event, due primarily to the scope and scale of the crisis, as well as with how quickly it escalated into a Province-wide event. This event required the entirety of the CIP and its resources, as well as significant additional pressures on the responding CIC, outside of what was normally expected to manage on a more 'routine' deployment. When this occurs there is ***a requirement for the strategic and operational aspects of command to transition to a higher level, leaving the tactical command (apprehending the suspect in this case) remaining with the CIC***.

CIC Role and Response to the JSCN/Weldon event:

As explained earlier, Staff Sergeant Bergerman, the initial CIC, had been notified by the MOSS Unit at approximately 6:47 am of what was unfolding at the JSCN. After being notified, Staff Sergeant Bergerman travelled from Prince Albert to JSCN. Staff Sergeant Bergerman had been in communication with the MOSS member(s) prior to his departure and was receiving information and updates while travelling to the JSCN. This communication allowed him to be aware of what he was confronted with when he arrived. Further, he was briefed by Staff Sergeant Simons and others first responding members upon arrival with the most recent information. ***Upon his arrival at approximately 9:00 am, Staff Sergeant Bergerman took over command of the incident*** and would assume command for the first 11.5 hours until he turned command over to Inspector Pugh.

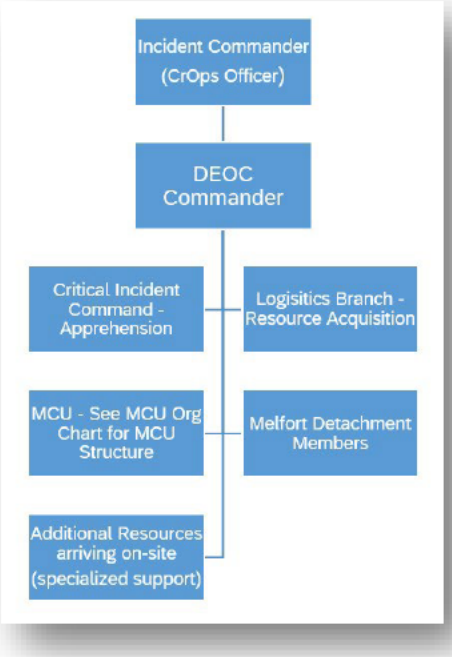
Inspector Pugh was not on-call during the initial call out on September 4th but was notified of the situation via the related ERT call out that had been made. Inspector Pugh had his portable radio and laptop at his residence and was monitoring the situation prior to taking over from Staff Sergeant Bergerman.

Effective Practice: Although not required, the involved CIC's had their portables and laptops at their residences, allowing the incumbent CIC to have the highest level of situational awareness at the time of transferring command.

Additionally, the two were in regular phone communication where information was shared as the situation was evolving. Inspector Pugh was part of fulsome daily briefings held through the DEOC in Regina which supplemented the information he had when he was preparing to take over command. This allowed for a seamless transition between the

incoming and outgoing CIC. ***The CIC role was continuous for the duration of the event***, with trained CIC's occupying the role throughout.

CIC arrival in the area of the JSCN ***replaced the regular command and control*** direction being given by the first wave of initial responding members (described in the previously) and resulted in a ***more formalized command structure***. The CIC mission was ***'to safely apprehend the suspects and recognize safety for the public, police officers, and the suspect'***. During this time, the DEOC was in the process of being activated and staffed (discussed next) and MCU had also been deployed as it was clear the extent and nature of what was transpiring was going to require the highest level of investigation in many different areas. (MCU involvement will be explained in greater detail later in this report).



Expanding Org Chart – CIC arrival

Establishing the Incident Command Post:

By definition, an Incident Command Post (ICP) signifies the physical location of the on-scene incident command. One of the first responsibilities of the Incident Commander is to establish command by setting up an ICP to promote clear lines of authority and

communication for the incident. ***Ideally, a single command post would be identified and positioned as close as possible to the area where the event is occurring.*** Other sections might have command posts that are responsible for certain aspects of an operation; however, there should be only one ICP from which the entire operation is managed.

An ICP can take on different forms such as the mobile CP's that are part of the Critical Incident Program or simply the vehicle that the CIC is driving. The ICP that is utilized by the CIC is widely known as an ***ERT Command Post (ERT CP)*** and will be referred through the remainder of this report as the command post that the CIC was working from, on-site, during the JSCN/Weldon event.

ERT CP (CIC):

CIC requested the ERT CP immediately after being notified on September 4th, from the Critical Incident Support Unit. This unit falls under the direction to the CIC and one of it's responsibilities is the set up and maintenance of the four mobile command post's that 'F' Division has access to.

Effective Practice:
To assist with efficient deployment of the ERT CP, the Critical Incident Support Unit in 'F' Division is scheduled to on-call rotations and take direction from the CIC.

The units, however, are located in Regina and were not available upon CIC arrival at the JSCN. There was a JSCN Command Post that was stood up at the Band Office that was being utilized by Band members to manage the incident for their purposes but was not the appropriate place for the CIC to work from as it was not a secure area. As such, Staff Sergeant Bergerman was working out of his truck until around noon on September 4th, when the ERT CP arrived from Regina.

Recommendation 2.1 – Consider splitting Mobile CP resources to have equipment available for deployment in a more northern location.

In the end, three Mobile CP's were utilized for the JSCN/Weldon event but for the purposes of this section, ***only the ERT CP will be reviewed***, as the remaining were used mainly as a 'home base' for other responding units to converge rather than a headquarters for directing the coordinated emergency response.

Ideally, Staff Sergeant Bergerman wanted the ERT CP to be set up on the JSCN; however, he was of the understanding that the radio reception on the JSCN was insufficient, so he requested initial set up in Melfort. Once it was learned that the ERT CP had radio booster technology, it was moved back to the JSCN the following day and remained there for the

duration of the event. Admittedly, CIC was aware of the optics, from a community perspective, when the ERT CP was moved out of the JSCN, and the barriers that relocation can create. The decision to transition was made out of a perceived operational need and once any issues were rectified by the Critical Incident Support Unit members, ***CIC remained in the JSCN area for the duration of the event***.

As will be outlined below, ***a single ICP responsible for the entire JSCN/Weldon event was not utilized***. The CIC worked close to the actual incident out the ***ERT CP*** for the majority event. This was the command post where tactical decisions were being made in order to apprehend the suspect. For most incidents, all responsibilities of 'overall command' would be managed out of this single command post; however, due to the scale of the JSCN/Weldon event, the DEOC organically became the ***Incident Command Post***, as it was the location that was privy to the most up to the minute information and hosted all higher level operational briefings.

This structure ultimately allowed the CIC situated on-site, in the ERT CP, to continue with their apprehension efforts, while simultaneously allowing for the completion of the multiple other responsibilities that otherwise may have deflected from their tactical focus. At the same time, however, the ***evolution of the DEOC as the ICP*** seemingly contributed to ***lines of command becoming somewhat unclear at certain points***.

ICP Location:

The location at which those in command positions are making key decisions will always be subject to debate. Discussion points surrounding the distance from the incident that command is located during a large scale deployment of resources will get extensive deliberation. However, it is important to note that advances in technology have altered the need to always be as close as possible to the scene and is not uncommon for the ICP to be co-located with the incident base. For example, wireless devices now have the ability to broadcast much further and more efficiently than in the past. It is not unreasonable to have the ability to establish strong situational awareness from a greater distance.

The CIC considered working out of the DEOC but ultimately decided on positioning close to the event. If the equipment and technology in the 'F' Division DEOC was modernized, it may have been a viable option to command the entire event, ***including the apprehension efforts***. Modernization of the DEOC and efforts being made to do so will be discussed later in this section.

Major Crimes Unit (MCU):

Although not a traditional command structure, MCU utilizes the principles of Major Case Management (MCM) when conducting investigations. MCM uses a hierarchy of command and roles based on 'industry standard' established principles of conducting criminal investigations. Circumstances surrounding the JSCN/Weldon event caused the MCU structure to expand in concert with the evolving situation. As the structure expanded, so too did the reporting lines. This organizational expansion, along with a further explanation of MCM will be addressed later, in the Major Crimes Unit portion of this report. The reason it is introduced here is based on how it actually interfaced with the other command structures utilized in the JSCN/Weldon response.

Command Uncertainty:

As discussed previously, command lines were occasionally unclear and created uncertainty surrounding who was responsible for issuing some of the tactical direction. Perhaps the defining moment for this was on September 7th, when the suspect vehicle was observed and the eventual pursuit that ensued.

For context, after the suspect vehicle was confirmed and a pursuit ensued, the suspect eventually reached speeds of approximately 140 km/hr travelling southbound, in the northbound lane South of Rosthern on Highway 11 toward Saskatoon. Highway 11 had been blocked off at Saskatoon to the south; however, there was traffic that was still traveling in between, that was at risk.

During this time, Inspector Chamberlin and Chief Superintendent Munro were situated in the DEOC and were receiving information from the MOSS member that was monitoring the pursuit in real time. The CIC at this time was not in the area of the pursuit and was perceived by those located in the DEOC to not have the situational awareness that was available in the DEOC at that time.

Chief Superintendent Munro and Inspector Chamberlin had a brief discussion where a determination was made to issue the direction to take the suspect vehicle off the road. Any amount of time lost relaying updates to the CIC in order for him to make this tactical decision would have taken too long, given the circumstances. Chief Superintendent Munro told the MOSS member to transmit direction over the radio for members to use whatever force necessary to stop the suspect vehicle. The MOSS member situated in the DEOC followed the directive, however, was confused by the order as the belief was that the CIC or the MOSS member himself should have been issuing that tactical directive.

To mitigate the confusion surrounding the perceived deviation of the command structure in a broader sense, communicating earlier on during the course of the event that the DEOC was in fact the Incident Command Post that had overarching authority, with the ERT CP commanding the apprehension aspect of the operation, may have alleviated any uncertainty from those involved. In the moment, however, those in position to provide direction from the DEOC, would have benefitted by have broadcasting their authority and made it clear that they would be making the necessary tactical decision at that time, without interference.

It must be noted that ***both the CrOps Officer and the DEOC Commander have vast incident command experience and were fully qualified to provide direction during the pursuit.*** The CIC further acknowledged that they would have issued the same direction, but ultimately felt it should have come from CIC and not those commanders situated in the DEOC. Where that situational awareness does not exist, it is vital that the CIC be directly linked to the ICP. Whether this comes in the form of being physically present in the ICP, or virtually, through technology.

Recommendation 2.2 - On large scale incidents it is critical that the CIC is directly embedded in the ICP or linked in via technology to be sure there is full situational awareness with all commanders.

Recommendation 2.3 - Physical relocation of the ICP to a location closer to future events of this scale should be considered as a measure to alleviate some of the communication gaps experienced. Alternatively, should it be decided by command that the ICP should be located in the DEOC, provide a clear announcement advising of that designation.

It is conceivable that, as a force, the RCMP will be required to respond to other events of this magnitude. Developing specific plans for this type of scenario ahead of time will benefit response and offer clarity of direction for these seemingly inevitable situations.

Recommendation 2.4 – Consider designing a 'crimes in action' protocol for the Division that includes organizational chart templates for roles necessary to fill, should an event of this magnitude transpire again. This would promote an organizational structure to be present at the onset of the event. Within this structure, roles and appropriate reporting lines between the DEOC, CIC, MCU, etc. can be outlined.

An alternative may be to explore the idea of having multiple CIC's engaged, based on the size and scope of the event, with clearly delineated roles so as not to overlap areas of responsibility. In the JSCN/Weldon situation consideration may have been to have a CIC

in charge of apprehension efforts on-site, and a second CIC situated in the ICP at DEOC, if this is the preferred location, for the remainder of the division.

Ultimately there was an agreement as to the decision that was made and ***any uncertainty surrounding the command structure at any point in time had no adverse effect on any outcomes*** in the overall event. The JSCN/Weldon event may have symbolized the fact that there is no singular blueprint or universal approach to reacting to events such as these and it was this the ability of the various levels of command to work together effectively in the moment that allowed them to overcome any momentary confusion related to command.

Recommendation 2.5 - Commit to and implement a major event command system for the division. Liaise with counterparts in other divisions to explore their standardized systems. Explore and support appropriate training at all levels of membership. Include National Operational Readiness and Response unit to ensure the greatest consistency around implementation.

Command Summary:

Responding to and commanding an event of this magnitude does not come without challenges. Regardless the level of command that was recognized at any given time, the reality was that the RCMP was reacting to a situation that was evolving and had not yet stabilized. Suspect(s) were at large, and until they were apprehended, there could be no confirmation that their spree of violence was over. The element of time was a factor that loomed large over the entire police response, until such time the suspect was taken into custody on September 7th.

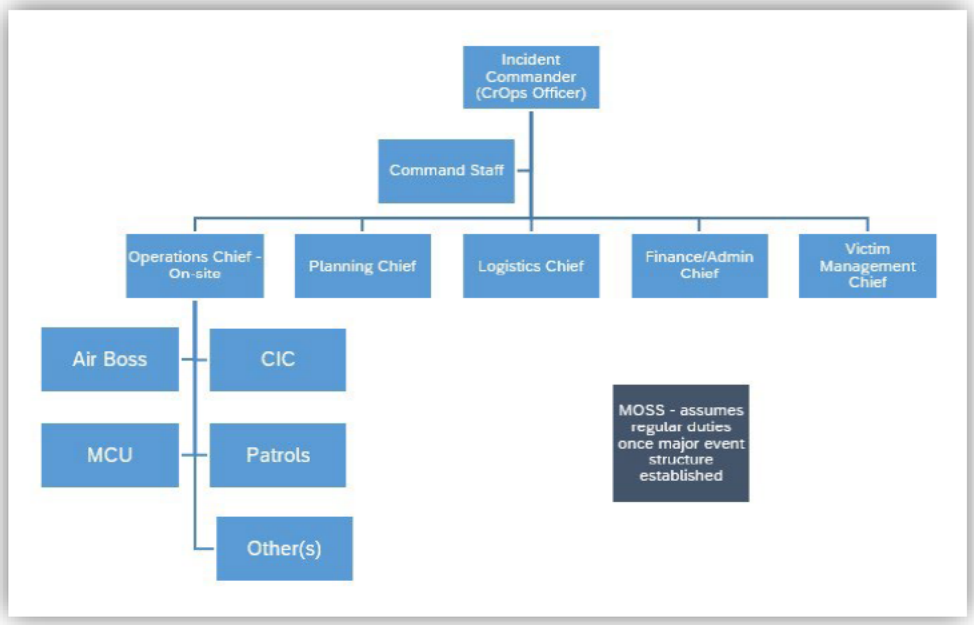
Despite the challenges, ***appropriate levels of command were activated early and used effectively*** throughout the incident. Any command challenges noted throughout this review were mitigated by the positive working relationships amongst the senior RCMP management in 'F' Division. Overall, the command structures being utilized and followed provided an extraordinary response to the victims of the tragedy and the pursuit of the suspects.

The intent of this section is not to argue the strengths and weaknesses between ICS and GSB, but rather to emphasize the ***necessity of committing to a structure*** and the recognition that the processes and methodologies of these systems allow for the opportunity to make better decisions. In the absence of any policy at the National or Division level, the issue will remain as to what the standardized command structure will resemble, when localized events evolve beyond existing command structures.

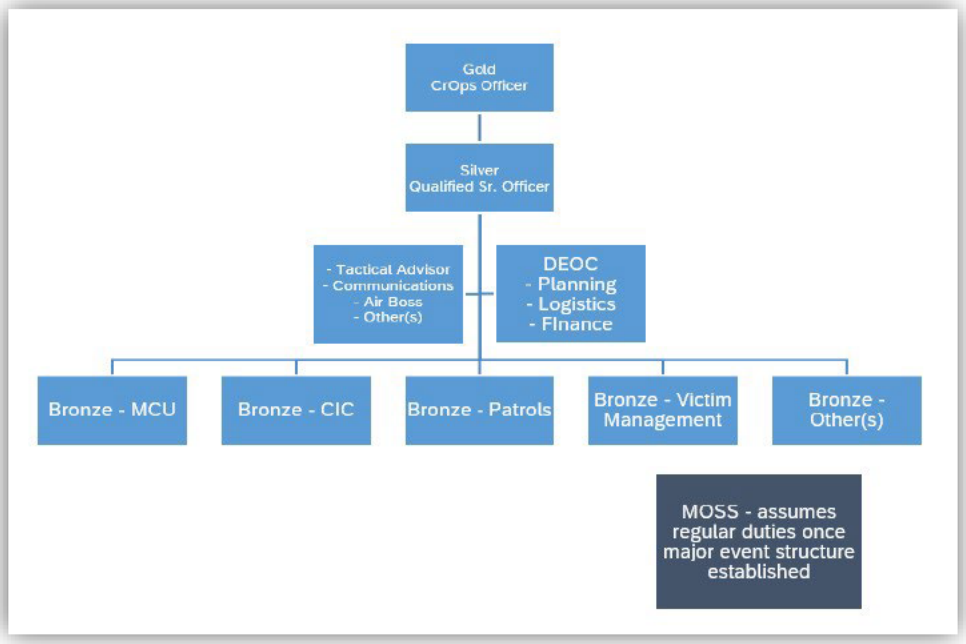
Brief Commentary on ICS/GSB:

As previously mentioned, there was not a comprehensive organizational chart created for this incident, at the time. As such, the review team was not able to reconstruct the command structure as it might have been exactly. In lieu of having such a chart, the review team created various conceptual organizational charts, as best could be determined, from all participant interviews. As the Division and National Criminal Operations consider what might be the best command model for major events, it might be helpful to have a vision of what the organizational chart might have looked like, at the higher levels, had either the ICS or GSB models been utilized more exclusively.

Outlined below are 'conceptual' organizational charts of how the ***higher levels of command*** could have been set out, for a major event such as this.



ICS Conceptual Organizational Chart – JSCN/Weldon



GSB Conceptual Organizational Chart – JSCN/Weldon

*Note in the above charts, DEOC and MOSS are included considerations. In the approval of any model that might be finalized, the DEOC and MOSS (or RTOC) models, should also be a consideration within any resulting Division or National policy.

The above conceptual organizational charts, albeit extremely brief, are not provided to endorse one model over another. The pros and cons of each model, as well of others, would require a much deeper analysis than could be effectively provided within this report. The more important reason for including the conceptual charts is to further identify how having a clear command structure, within our RCMP environment, might help us to ensure the greatest clarity of command for future major events.

Further Command Findings

DEOC Functionality:

Although not specifically related to commanding the overall event, the physical structure of the DEOC was mentioned on a number of occasions to be outdated and inadequate in both size of the space and workstations alike.

There is a technological gap that exists in the DEOC. The DEOC has access to the Computer Integrated Information and Dispatch System (CIIDS), described further in the Operational Communications Section. Briefly, the CIIDS system allows for the most widespread, real time picture of what resources are in play and where those resources are located. The DEOC has a dedicated television that accepts the CIIDS system that did not work on the first day. Although Informatics employees are not 'on-call', an employee was available on short notice and was able to fix the issue. This raised the point of considering an on-call rotation for Informatics. The larger problem still exists, however, where there was an inability to track resources at the initial stages of incidents such as this.

Recommendation 2.6 - Consider options to modernizing the DEOC. Examine feasibility of re-organizing or re-locating the DEOC, including investment in technology and infrastructure.

The DEOC appeared at times to be too easily accessed during the JSCN/Weldon event due to the overwhelming amount of people that were in the DEOC at any given time. The issue was exacerbated on September 4th when Inspector Devin Pugh (Inspector Pugh) was working out of the DEOC in a CIC capacity (described in the following section). The commotion in the DEOC caused him to move first to the building cafeteria and eventually to the JSCN where he setup in the command post. CIC felt better able to deal with the event from this position and felt that the DEOC was not the appropriate place for him at that time. Although the decision to move to the CP was probably the best choice for the CIC, it highlighted the issue with the DEOC space and the number of people, especially those that were not required, that were present during decisive moments.

Further, on September 7th, during the pursuit and eventual arrest, senior management was filling the DEOC room, providing direction during the pursuit. The atmosphere was described at time as 'chaotic' and was limiting everyone's abilities to function at capacity. Along with any potential revamping of the DEOC as a result of this event, consideration

should be given to efforts in restricting access to the DEOC to only those in senior management that are required to be present.

In late 2022, the F Division RCMP instituted a ***Division Innovation Committee*** and determined the need to modernize the DEOC as one of its priorities. The latest major incidents in Saskatchewan highlighted the need for enhanced and improved technological gaps within the DEOC. Work has begun to identify an increased capacity to stream live video feeds to the DEOC along with increased connectivity to the Android Team Awareness Kit (ATAK), Wi-Fi line speed, cellular boosters and PPSTN network coverage.

A project led by 'F' Division Asset Management and Informatics will be working on renovating the current DEOC space with the objective of improving the ergonomics, operational space and increasing the capacity to work inter-operably with other Provincial and Municipal agencies.

Containment:

Since suspect identification occurred very early in the JSCN/Weldon Event, one of the primary objectives when CIC entered the picture was containment. Perimeter control and containment are a crucial part of the immediate response to a critical incident and is a prerequisite for establishing incident command. Naturally, efforts to contain the suspect(s) initially was the most crucial task for the CIC.

Initial containment was admittedly a struggle as it took longer than anticipated, mainly due to the limited resources that were available at the time and the distance that the JSCN was from where those resources would have been deployed from. Further, once resources began to arrive, there were difficulties in tracking them (discussed below). That being said, CIC believed that the manner in which the incident was resourced was appropriate under the circumstances. OCC/MOSS were dispatching all available resources at the time and in turn, the CIC was doing its best with the resources they had. The CIC was communicating with the Saskatoon Police Service (SPS), Prince Albert Police Service (PAPS), and Regina Police Service (RPS), utilizing both Provincial Traffic and RCMP Traffic Services for assistance with containment efforts. By 9:35 am, check stops were set up on Highway 3 at Prince Albert, Highway 6 south of Melfort, and the Highway from Melfort to Kinistino. MOSS contacted SPS and initiated check stops for Highway 11 North.

All that being said, the reality that the CIC faced in terms of how resources were deployed, was that the suspect(s) whereabouts were relatively unknown. As mentioned earlier in the ***Chronology of Events***, the suspect's Black Nissan Rogue was confirmed on video

surveillance at 7:27 am on September 4th in Weldon. Almost a half hour later the perimeter expanded when a possible sighting was reported approximately 28 kilometers southeast of Weldon (near Beatty, Saskatchewan). A believed reliable sighting in Regina at around 12:00 pm caused a shift in focus to that location until later in the day when the information was discredited. Further reliable sightings would not be received until later in the afternoon on September 4th when there were multiple reports of sightings in the Crystal Springs area, between 4:00 pm and 8:00 pm. Between September 4th and September 7th, numerous tips were received from the public reporting sightings both in Saskatchewan, and across Canada. Needless to say, without reliable intelligence, the best that could be done was to make an inference as to where the suspect could have been.

Over the course of the following days, the CIC deployed all available means in an attempt to narrow down the area where the suspect could have been, but it was not until the events beginning at 2:06 pm on September 7th when the suspect stole a White Chevy Avalanche from an acreage near Wawka that any type of containment was achieved. By 3:17 pm RCMP had located the suspect traveling westbound toward Highway 11.

CIC Support:

During the initial stages of CIC involvement, there was an extraordinary amount of information being received. In situations such as these, scribes allow for the real time documentation of the CIC critical decision making processes and the resultant tasking of resources in order to meet the objective(s). Strategic conversations had by the CIC in order to reach decisions can be captured by scribes and the documentation of these decisions can assist in answering many post-event questions based off the principle of 'what did we know and when did we know it'?

The CIC has a dedicated scribe; however, during this time that resource was diverted and another scribe was not requested. Instead, CIC utilized another regular RCMP member to accompany him, in a scribe capacity. Although not ideal as the replacement scribe was not trained, the CIC did what it could in order to properly document information and decisions. Nonetheless, a dedicated scribe for the entirety of the event would have been beneficial.

Recommendation 2.7 - Identify division scribe resources and managers and explore the possibility of a scribe program that will automatically dedicate a scribe to CIC call outs.

Common Operating Picture (COP):

Inspector Pugh admittedly had limited knowledge of where general duty resources were located at any given time when he took over CIC duties on September 4th, which highlighted the need for an all encompassing ***Common Operating Picture (COP)***.

A ***Common Operating Picture*** is a display of relevant information that enables those in command and control of a situation to make informed decisions based on situational awareness. When performing at its best, a COP is available on a single display where information (such as location of resources) can be viewed by more than one command.

In the case of the JSCN events, a COP would have been useful, not only for CIC (who (located on site), but also for the DEOC (in Regina). As the event gained attention nationally, leadership in Ottawa began requesting updates and information. The demands from NHQ became unmanageable as everyone in the home division was already heavily tasked with no one to delegate to. NHQ did send assistance; however, by the time the resource arrived on September 6th, a large portion of time that any further assistance could have been offered, had passed.

Common Operating Picture capabilities may have alleviated some on the pressure experienced with providing updates to National HQ; however, there are several benefits that can come from having a NHQ resource directly at the event. When NHQ is kept apprised of the situation, especially in real time, it puts them in a better position to assist rather than viewed as an added layer of reporting structure.

Recommendation 2.8 - Consider requesting a resource from NHQ to travel immediately to the location of a potentially prolonged major incident to take on the role of National/Division liaison.

Alternatively, for those divisions who are engaged in proficient Emergency Management Systems (EMS), there may also be a remote option through these systems a receive regular situational reports and to have access to the event electronically. Although EMS not a focal point of this review, it is worth mentioning as an option at this stage.

For evolving incidents such as the one that occurred at the JSCN/Weldon, a real time COP is essential. Resource allotment was a large part of the initial response as command was dealing with securing multiple scenes as well as containment. Knowing what resources were available and where they were located, was crucial and has been addressed in previous reviews of this nature.

To mitigate the absence of a COP, steps were taken to create a 'makeshift' COP through members utilizing CIIDS (via mobile workstations), members that had access to the ATAK

app on their cell phones, and the SAMM function on mobile workstations. The SAMM feature, as will be discussed in the review of Operational Communications, offered some remedy to tracking; however, it was dependant on an individual member's awareness that they could update their status, as per policy, on their own. Although the combination of these functions increased the ability of the various Commanders to allocate resources, they did not provide a fulsome picture of situational awareness at any given point.

ATAK will be mentioned at various points throughout this document as a potential remedy to tracking and communication gaps that occurred during the JSCN/Weldon event. As such, what follows is a brief overview of ATAK and its capabilities in order to provide context to areas where it is mentioned.

ATAK is a software application and mapping framework for mobile devices that promotes effective information flow and communications from the field to the various command locations (mobile command posts, DEOC). The app's capabilities also include text messaging, distance measuring tools, access to satellite imagery and terrain, chat and video communication, and tools to share information that will increase safety and collaboration. ATAK can provide a real-time view of operations by showing member locations on multiple devices, such as android phones or large-screen televisions. This information can be shared locally, regionally, and nationally.

The RCMP interest in ATAK as a contributing element to a COP stems not only from the tactical advantage that it offers, but more specifically from the ***MacNeil Report***, which provided the following recommendations related to COP's.

Recommendation from MacNeil Report (Moncton 2014):
3.4 The RCMP explore options that would allow for a common operating picture (COP) to be available for simultaneous monitoring by frontline supervisors, Critical Incident Command, Division Emergency Operations Center (DEOC) and the National Operations Center (NOC). Such technology should have a mapping system capable of plotting resources, sharing information with other users and linking to operational dispatch systems that track police vehicle locations and individual officer movement.

7.8 It is recommended a high resolution mapping system, such as the web-mapping service from the NOC, be integrated within CIIDS, having the ability to share such vital information as perimeters and location data.

7.9 It is recommended the RCMP research options for providing GPS tracking ability for members to ensure they can be located and tracked when dismounted from their vehicles.

[redacted]

[redacted]

[redacted]

Recommendation 2.9 - Continue investment in Common Operating Picture software. Continue efforts toward installation and training on ATAK or some type of system that allows for tracking of resources. Ensure the DEOC is considered in any technological upgrades.

RCMP Air Services

The RCMP's Air Services provides direct operational support in technical and specialized areas of airborne law enforcement, enabling front-line members to preserve the peace, uphold the law and prevent and investigate crime. Air Services is able to mobilize personnel and equipment necessary to meet the diverse demands of the RCMP and provide support to the RCMP in both heavily populated and remote areas of Canada.

The RCMP's mission specific fleet of fixed and rotary aircraft are strategically based in locations across Canada. 'F' Division Air Services has two Air Bases located in Regina and Prince Albert and have access to three aircraft on strength, but only two were operational at the time of the JSCN/Weldon event.

The ***Regina Air Base*** operates the ***Pilatus*** PC 12/NG [redacted] fixed wing (***C-GMPW***) and the ***Cessna*** T206H fixed wing aircraft (***C-FSWC***).

- GMPW is distinct [redacted] and is typically used for passenger transport.

- The Cessna was ***not operational*** at the time of the JSCN/Weldon event (explained further below).

The ***Prince Albert Air Base*** operates the Pilatus PC 12/NG fixed wing aircraft (***C-GMPA***). This is a typical Pilatus PC 12 aircraft. It is virtually identical to C-GMPW but it is ***used only for transporting personnel and cargo***. [redacted]

'F' Division Air Services has access to other RCMP aircraft and personnel or equipment in other Divisions during an emergency, pending approval by senior management in the Division and Air Services Branch (ASB) in Ottawa.

Throughout the entirety of the JSCN/Weldon event, the following air assets were either requested and/or utilized:

- 'F' Division fixed wing plane PC12-47 [redacted] (C-GMPW);
- 'K' Division helicopter AS350/H125 (C-FMPP);
- Saskatoon Police Service plane (SPS plane);

- 'O' Division fixed wing PC12-47 [redacted] (C-GMPB);
- [redacted]

Operational Availability:

The CIC immediately identified the requirement for air support when notification of the unfolding events on the JSCN was received on the morning of September 4th. The fact that the suspect(s) had yet to be located and were said to have been mobile, in a vehicle, brought about the evident need to locate and contain he suspect(s). Utilizing aircraft in an effort to contain and locate the suspect(s) was seen as a viable option.

'F' Division Air Services was contacted by the MOSS Unit on the morning of September 4th and were told that the ***Cessna aircraft was not operational*** at the time. As such, Saskatoon Police Service was contacted, resulting in their ***SPS plane*** being airborne by approximately 8:00 am. The Cessna is the aircraft that the Critical Incident Program most often requests [redacted]. The SPS plane has the same capabilities and is often requested instead the RCMP asset. [redacted] however, the mission equipment on this aircraft is obsolete and requires significant upgrading. The product produced [redacted] is severely lacking in quality and would have been ineffective for use in the JSCN/Weldon event. The similar type aircraft from 'O' Division (GMPB) and C Division (C-GMPQ) had updated equipment and was in better position to assist should there have been the requirement for quality photos and/or video.

This inability to readily assist with operations led to an underlying belief that contacting and obtaining RCMP Air Services and their assets is difficult and cumbersome. If the assumption is that RCMP assets are difficult to obtain or that they will be unavailable, alternative air support is generally sought for urgent requests, as was the case with securing the SPS plane.

Air Asset Management:

Inaccessibility is not necessarily the issue, however, when you gain an understanding of the ownership of 'F' Division air assets. In 'F' Division, the ***Federal Government does not own the planes***, but rather the Provincial Government leases them. In the case of MPW for example, any upgrades to the aircraft, [redacted], need to go through the Government of Saskatchewan. The Cessna, which is a federally owned aircraft had been grounded for ***ergonomic and egress issues***. Although there is a recognized need to upgrade mission equipment and remedy the issues

preventing the use of certain assets in order to resume those duties in support of frontline policing units, the Provincial government seems reluctant to supply the funds. 'F' Division Air Services have submitted multiple business cases to the province and now, following several high profile cases, are hopeful of making progress. All this puts 'F' Division Air Services in a difficult position as far as being able to efficiently assist with operations.

After the SPS plane was secured, 'K' Division's helicopter ***(FMPP)*** was requested and arrived in the Rosetown area by 2:06 pm on September 4th. During this time, information was being reported that both suspects were in Regina and were exploring options of turning themselves in. A tip from the public was also being reported to the Regina Police Service advising of a sighting of the Black Nissan Rogue that had been part of previous Public Alerts. ***A plate number of the vehicle was not relayed to the operator***; however, the plate number for the vehicle that was known to have been driven by the suspects was assumed by the operator and forwarded as part of the tip. The plate information provided additional credibility to the tip and was the catalyst first for re-routing FMPP to Regina and secondly for another Public Alert being issued at 12:07 pm, advising of a suspect sighting on Arcola Avenue in Regina.

Ultimately there were no confirmed sightings of the suspects or the vehicle in Regina from that point onward. The tip information that was received caused a momentary shift of focus for a limited number of resources to the Regina area but did not divert the on-going efforts that were being made in the JSCN and Weldon areas.

At this time, however, other air assets were being secured from across the country and led to the decision to stage all air assets in Regina. This decision ended up being a hindrance as travel to the JSCN area required an additional 40-minute flight north, when required. To mitigate this, a decision was made to stage FMPP right at JSCN, as it was the slowest of the aircrafts.

Scheduling Issues:

Most gaps between 'F' Division Air Services and the CIC revolved around the ***scheduling and coordination of aircraft***. At one point it was noted there were six different requests coming in from various people. CIC, DEOC, OCC were all in positions where they were directly contacting the Tactical Flight Officer (TFO), pilots, base managers, or the OIC of Air Services. Because there was an on-going crisis, protocol was skipped.

Most notably perhaps, was during the afternoon on September 7th, after the suspect was identified at a residence in Wawka, it was discovered that all three air assets were down

for fuel in Prince Albert (discussed later). CIC was of the understanding that FMPP (helicopter) was available for air surveillance; however, they were unaware that MCU had utilized the helicopter earlier, causing it to require re-fuelling. This caused a delay at a critical time and perhaps highlighted one of the key issues during this incident; there were too many entities (Regina Air Base Manager, 'F' Division Air Services Line Officer, CIC, MCU, Tactical Flight Officer) competing for position with Air Services when the single point of contact such as an Air Boss or a Flight Coordinator (explained below) that could have directed all inquiries, was either not assigned or under utilized.

This led to a lack of clarity in the various roles and ultimately led to confusion on the part of the aircrew as to whom they should be taking direction from. For example, GMPW was being utilized [redacted], but also as a transport aircraft. There was a particular instance where the pilot was directed by the Regina Base Manager and the Line Officer to take on full fuel should he be deployed for longer periods [redacted] but then was asked to transport a full load of passengers out of Melfort. The aircraft has a maximum take off weight, and with full fuel, the pilot was unable to take all of the passengers because he had previously been instructed to take full fuel.

These particular decisions were not made by an Air Boss but rather by individual pilots based on direct communication with those commanders that they were speaking with first hand. During a time of crisis, a pilot will follow direction and because people were calling pilots on their own, they followed direction and at times, were essentially flying with little purpose. This may have been the cause of all assets being down for fuel at the same time in Prince Albert, just prior to the final pursuit on September 7th. This again caused a short delay and all aircraft were eventually deployed, which was not an ideal situation either. Identifying a situation where you have four aircraft in the same area would have been better managed by an Air Boss, or prevented all together due to safety reasons.

Further, from the perspective of National Air Services Branch (ASB), ascertaining what was required for resources when trying to deploy them to 'F' Division, it was difficult to get information. A first point of contact would have been the Flight Coordinator; however, that role was not utilized. This resulted in having to rely on the already deployed aircrew to provide the information required to adequately support 'F' Division Air Services. Communicating directly with a Flight Coordinator or if the assignment of an Air Boss was designated to this event, this scenario could have been avoided.

Air Boss and Flight Coordinator Distinction:

A Flight Coordinator and Air Boss have two separate roles. The ***Air Boss*** is can typically be any subject matter expert (SME) from Air Services who is experienced in both aviation

and dealing with Major Events or Critical Incidents. An Air Boss is typically embedded in the Incident Command Post.

Each RCMP Division has a ***Flight Coordinator*** assigned that, for lack of a better term, makes everything happen with regards to assigning air assets. Flight Coordinators view and prioritize the various requests, assess aircraft capability, assess operating environment, apply dispatch techniques, task aircraft, assign crew, and manage schedules. One of the most important assets in any division is the aircraft and the only way to have them operate efficiently, is through the Flight Coordinator. The ***Flight Coordinator*** is located at the base of operations and is responsible for directing operations at the base level, in accordance with operational flight requests and ***directions from the Air Boss***. At the very least the 'F' Division Flight Coordinator could have been that conduit from Air Services to the various requesting units but was seemingly omitted from any conversations about air assets.

The primary shortcoming in the Air Services response to the JSCN/Weldon event was a combination of local command's not requesting the assistance of the Flight Coordinator and not assigning the role of an Air Boss as part of the response.

This omission was addressed as the following recommendation from the ***2014 MacNeil Report.***

4.8 It is recommended in large scale events where Air Services is utilized, Air Services personnel with the appropriate training should be assigned to the Command Post as a liaison for air service support.

The requirement to have an experienced person that is familiar with 'all things' Air Services and put them directly in DEOC or the CP was a crucial step that was overlooked. What resulted was the potential strength of Air Services not being deployed properly.

Recommendation 3.1 - For any major events requiring air assets, the Divisional Flight Coordinator or an Air Boss should be identified immediately and situated in the ICP alongside command.

There is an apparent discrepancy to whom the responsibility falls to for assigning an Air Boss. Although the Air Services Line Officer was called in to 'F' Division HQ on the morning of September 4th as part of the initial call out, he was not designated as the Air Boss at that time. Amongst the planning that occurred in those early stages, the role of an Air Boss was not discussed, nor was it suggested, nor was it organically assumed by the Air Services Line Officer. Despite the Air Services Line Officer being present for DEOC

briefings, a designated Air Boss was not directly situated in the DEOC or alongside CIC and were not in a position to contribute to tactical decisions being made in real time. Having this ability would have alleviated many of these gaps in communication. In reality, 'F' Division Air Services do not work with the CIC very often and there is an apparent disconnect between the two entities as CIC have had limited success in obtaining RCMP assets and in turn, Air Services appreciates their frustration.

Regardless of whose responsibility it was to assign an Air Boss, the fact of the matter was that everyone involved desired the assistance of Air Services, but no consideration was given to appointing a single point of contact in order to make the process more efficient. This resulted in a loose structure of requesting Air Services assistance through whatever means was necessary, at any point in time.

[redacted]

[redacted]

[redacted]

[redacted]

The following was a recommendation from the ***2014 MacNeil Report***:

4.4 It is recommended that annual night training exercises with Air Services be developed and undertaken to maintain proficiency for ERT members.

Despite this, 'F' Division Air Services, the Critical Incident Program (CIP) and, by extension, the Emergency Response Team (ERT) had seemingly not practiced and trained together in an effort to better understand their interoperability of skills and tactics. This resulted in both programs not fully understanding each others capabilities during the JSCN/Weldon event, and forced everyone to learn on the spot.

Recommendation 3.2 – 'F' Division Air Services and the Critical Incident Program should practice together at least twice a year (1 day and 1 night) to maintain proficiency for ERT members and to better recognize the capabilities and limitations of each unit.

[redacted]

[redacted]

Recommendation 3.3 - Resolve the interoperability issues with Air Services communications and GPS systems to work seamlessly with ERT communications and equipment (ATAK).

Whether the result of communication issues, technological gaps, or the lack of interoperability with Air Services, the ability of CIC to respond appropriately to the situation was diminished.

[redacted]

[redacted]

[redacted]

[redacted]

Since the JSCN/Weldon Event:

Since the events on the JSCN/Weldon, a gap in availability of aerial surveillance capabilities across the country was identified by the Air Services Branch and, as such, steps are being taken to establish working groups with CrOps representation be brought together to identify and confirm high-level requirements and possible solutions. As a result of the recent high-profile incidents (such as the JSCN/Weldon event), there has been a greater demand for Air Service support. To better provide support to critical incidents, Air Services are in the process of reviewing their current service model in order to provide 24/7/365 support.

Major Crime Branch Response

'F' Division RCMP's Major Crimes Unit (MCU) is a unit made up of more than 30 RCMP investigators and a number of civilian employees that provide analytical, disclosure, and administrative support.

MCU serves all communities policed by the RCMP in Saskatchewan, including the JSCN and Weldon. In addition, they may assist independent police services to investigate homicides and suspicious deaths in their communities.

MCU in Saskatchewan consists of three teams, two in Saskatoon and one in Regina. Their Command Structure consists of an overarching Superintendent and an Inspector (currently vacant). Each team is led by a Staff Sergeant, followed by Sergeants, Corporals, and Constables. Members of the unit are highly trained, experienced and dedicated. MCU investigators attend a variety of training through the Canadian Police College, along with a multitude of courses related to death investigations, interviewing techniques, disclosure, forensic and digital evidence, major case management, and writing a variety of judicial authorizations such as search warrants.

MCU primarily responds to and investigates homicides, but may also attend or provide support for:

- Deaths resulting from police actions or deaths while in police custody
- Missing persons where foul play is suspect
- Incidents that are likely to draw major political, national or media attention
- Active shooter, hostage, barricaded, hijacking incidents, abductions or kidnappings
- Serious injuries or death to a member on duty
- Suspicious found human remains
- Serious member-involved shootings
- Any incident or investigation, at the discretion of the OIC or his/her designate

When responding to homicides, MCU are in charge of coordinating the various assisting units and managing the crime scenes.

Initial MCU Response and Assignments:

Staff Sergeant Rob Zentner was on-call for MCU on September 4th and was notified of the evolving situation at the JSCN at around 7:00 am. The information he received at that

time was that there was at least one deceased and two suspects. Call-outs to team members commenced immediately through their normal process.

Upon arrival at their Saskatoon office and prior to departure to Melfort, a number of related PROS complaints were reviewed and it became apparent that the number of victims was rising quickly. As such, arrangements for additional resources outside of the immediate MCU team that was responding, were made. By the time the responding MCU team had departed from Saskatoon to Melfort, the number of deceased had increased to seven. The entire on-call MCU team of eleven members were utilized in addition to the following:

- Ten members that were on Operational Availability (OA);
- Canvassed members that were not on OA;
- Additional Saskatoon MCU Teams;
- 2/3 from the Regina MCU Team;
- Historical Homicide Unit members;
- 'F' Division GIS resources;
- 'K' Division MCU resources; and
- 'K' Division MCU took on-call for the 'F' Division MCU.

One Saskatoon MCU member who was unable to deploy on September 4th was tasked with gathering information over the phone directly from the responding Melfort RCMP members while others were preparing for departure. This allowed for a timely briefing to occur amongst the Saskatoon MCU resources at 8:45 am, prior to their departure. The following information was provided at that time:

- An initial complaint was received by the Melfort RCMP reporting the incident;
- Approximately twenty other complaints had been received since;
- There were reports of two people breaking into residences on the JSCN;
- ERT/Police Dog Services (PDS) had been deployed to the area in an effort to locate and arrest the suspects;
- Suspects were identified, descriptions were provided for them as well as the vehicle they were reportedly in possession of (Black Nissan Rogue);
- The JSCN Band Office was being used to stage victims and STARS had already begun transporting victims out of the community;
- Seven people were confirmed to be deceased and the exact number of injured was unknown at this point; and

- Police were also responding to a complaint in Weldon, where a younger male showed up with a cut up face and asked to go to the hospital. It was unknown if this complaint was related at this point in time.

Following the initial briefing, a further update was received from the Staff Sergeant Simons advising that the number of deceased had risen to eight, with fifteen injured, and at least sixteen separate crime scenes. The deployment to this mass casualty event was unprecedented and as such, the scope of the MCU response changed from a 'traditional' call out. For example, Superintendent Josh Graham (Superintendent Graham) who was in charge of the Major Crimes Unit, deployed to the Melfort/Prince Albert area to work directly with his team. Under normal circumstances the Officer in Charge (OIC) of MCU would be made aware of a team being called out, but would not attend the specific call for support. The OIC, who was off work at the time, returned promptly and provided further investigative support to the MCU team and shouldered many of the bureaucratic tasks that eventually would allow the team to function more efficiently.

As set out previously in the Command Structure section, because of the size and magnitude of the unfolding event, the DEOC became the Incident Command Post and was the location that many decisions, some of which affected MCU, were being made. For this reason, there may have been value for the Superintendent to travel to Regina and be present in the DEOC instead of fulfilling his role, closer to the scene. Having said this, Superintendent Graham liaised with the DEOC regularly, was part of the DEOC briefings that were being held, and there was MCU representation situated in the DEOC over the course of the three days. Despite this, there were occasions when key information was not communicated through the proper channels to MCU resources. This was more due to lack of identified workflow and these considerations will be discussed further in the ***Major Crimes Branch Response*** portion, later in this document.

MCU operates within a ***Major Case Management*** framework which is a methodology for managing major investigations that provides accountability, clear goals and objectives, planning, allocation of resources and control over the speed, flow, and direction of the investigation through the following nine principles:

- Command Triangle;
- Communication;
- Leadership and Team Building;
- Management Considerations;
- Investigative Strategies;

- Ethical Considerations;
- Accountability Mechanisms;
- Legal Considerations; and
- Partnerships.

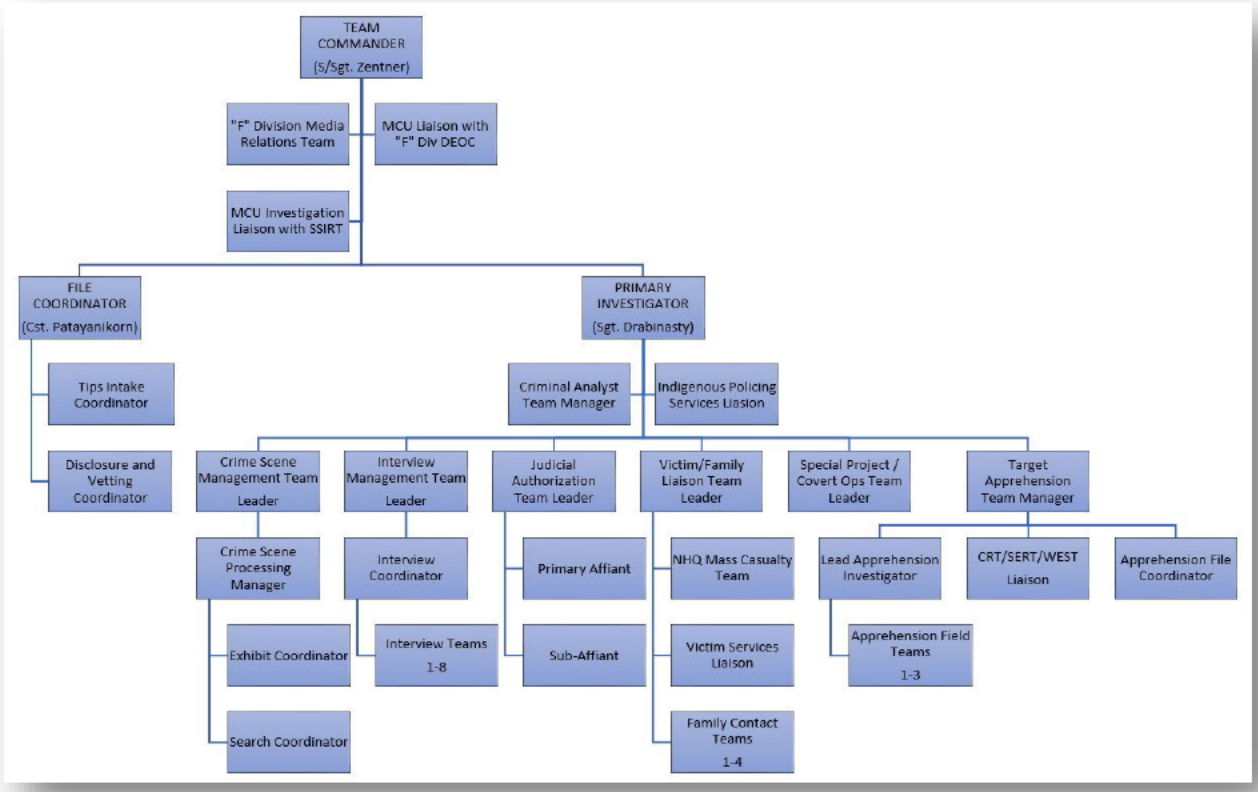
One of the first steps when functioning within this framework is the requirement to identify a ***Command Triangle (CT)*** consisting of a ***Team Commander (TC)***, a ***Primary Investigator (PI)***, and a ***File Coordinator (FC)***. In a 'normal' investigation, all MCU resources are aware of the reporting lines and information flows from the various investigators through the CT in order for a methodical decision making process can take place.

In the case of the response to the JSCN/Weldon event, ***CT roles were based off skill and experience*** and this was evident in the forethought that was given to investigative roles that were assigned. The TC was one of the most experienced homicide investigators in the province. The PI position wasn't assigned to the member next in line to take on this role and instead it was transitioned to a more senior and experienced member who also had a vast amount of homicide experience. A member that excelled in organizational skills was tasked to be the FC.

Effective Practice: Due to the nature of what was transpiring on the JSCN and in Weldon, additional 'Team Lead' positions were created in real time in order to delegate the crucial investigative roles that were anticipated given the circumstances.

Members were shifted from roles of 'Field Investigators' to various positions. Some were assigned as being ***'Interview Coordinators'*** as it was anticipated that there would be a number of key interviews (witness and suspect) that would be required with teams of members completing those tasks. There were multiple scenes to secure and process so a ***Crime Scene Management Team Leader*** was identified. As the situation was fluid and it was not known what, if any, timely warrants would be required, a ***Judicial Authorizations Team Leader*** was identified. Given that the suspects were not in custody, a ***'Target Apprehension Manager'*** position was created to coordinate the efforts underway to locate and arrest the suspects. Although some of the 'sub teams' had their own internal reporting structure, all eventually reported to the TC, creating somewhat of a hybrid command. This modification did nothing to lessen the effectiveness of the reporting structure but rather it worked to streamline the communication processes with MCU.

Based on the number of victims (both injured and deceased) there was a quick realization that a significant amount of work would be required for the Family Liaison Role. Communication was made early on with Sergeant Ashley St. Germaine (Sergeant St. Germaine) of the Prince Albert General Investigative Section (GIS) and she was tasked to take the lead in organizing the ***Victim/Family Liaison role***. This tasking occurred while MCU members were still in the initial stages of processing the various scenes and making effort to apprehend the suspects. ***The actions taken by the Victim Support Teams are explained in greater detail later, in the Mass Casualty/Victim Response portion of this review.***



JSCN/Weldon Mass Casualty MCU Org Chart

In hindsight, the TC indicted he would have liked to have identified these lead roles earlier; however, the point at which they were assigned had the desired effect and ultimately

lessened the workload for the Command Triangle (CT) and made the flow of information more efficient.

Effective Practice:
As early as possible, given the size and scope of an investigation, identify crucial lead roles and delegate appropriate investigators to assume those positions. The creation of these roles allows for more efficient flow of information to the TC and PI and for more focussed tasking.

Both the TC and PI's phones were admittedly 'ringing non-stop' from the onset of them being called out and for much of the following days. The ability to properly document decisions and direction is crucial in these moments. It was noted that a dedicated scribe for the PI and TC would have been beneficial in order to take the onus off those in these crucial decision making roles to recall and document granular details of conversations or meetings that will likely be subject to some type of future disclosure.

Recommendation 4.1 – Explore the possibility of a scribe being assigned to the Command Triangle to capture decision making and content from briefings.

Resourcing:

As the situation on the JSCN and Weldon was evolving, essentially any investigative resource under the major crime branch was accessed. Inspector Chamberlin of DEOC reached out to the MCU team early advising them of whatever resources they required, they would get.

Federal investigators were used to assist with any [redacted], Special Tactical Operations (STO) teams from Alberta, any available resources from 'F' Division, 'D' Division (Manitoba), and PRT resources from the province assisted with scene security. [redacted]; [redacted] was engaged should they have been required; and Polygraph was engaged to deal with potential suspect interviews. All FIS resources supported further by Traffic Reconstruction members and Bloodstain Pattern Analysts (explained later) were engaged and assistance from the Division Criminal Analysis Section (DCAS) was requested almost immediately.

Although MCU teams do not have embedded analytical support, the DCAS manager contacted MCU while they were travelling to Melfort to determine what support they required. MCU requested analytical support from DCAS and were granted two analysts that attended the location along with MCU with others supporting remotely. One of the

attending analysts worked with the main investigative team and the second analyst worked with the target apprehension team. Analytical support received specific tasking from MCU which was clear and efficient for the DCAS resources that were deployed. DCAS resources were included in briefings and relayed information back to their managers located in Regina, in a timely manner.

Recommendation 4.2 – Assess the feasibility of having embedded analytical support for MCU teams as a standard procedure, for all major incidents.

Aside from the natural lack of resources upon the initial call out, MCU members did not identify any additional resources that may have assisted with their duties, aside from a system for tracking the resources that were already deployed. The ATAK system was mentioned as a remedy to this and will be covered in more detail in section(s) to follow.

Logistics:

MCU arrived at the Melfort Detachment at approximately 10:45 am on September 4th and utilized the detachment coffee room for their initial base. It was quickly ascertained that this was not an ideal location as the room was too small and there was insufficient bandwidth for ROSS/Internet/Shared Drive access to accommodate their needs. Meanwhile, they still had to allow for the detachment to maintain other normal business activities without interference. As such, on September 5th, the MCU team moved locations to the District Support Services Building in Prince Albert where they would remain for the duration of the event. Once requests to bolster the technology capacity were made, the Informatics Unit (described later) outfitted MCU with laptops, a smart board for planning and mapping purposes, portable radios, and the appropriate bandwidth for the movement of data.

Further to this, one of the mobile CP's (mentioned earlier) was set up in and used as a staging area for the MCU, Crime Scene teams and interview teams on the JSCN. The trailer was set up at the Band Office, beside the Critical Incident Commander in the ERT CP (described earlier), and the third mobile CP that was being used as a base for Crime Scene Security, Community Security, and other RCMP Support Services.

From that point onward, MCU was based out of Prince Albert. The decision by MCU to move their 'home' locations did not affect their ability to respond and investigate. If anything, the move enabled them to have a larger space with better access to technology. This move had no affect on the field investigators other than a minimally longer drive back to Prince Albert, when required to do so.

Recommendation 4.3 – Consider the creation of a MCU logistics package for expediting set up on initial call outs.

The number of scenes and exhibits that MCU and FIS were processing was uncommon. As will be explained later in this section, priority was given to any outdoor homicide scenes due to the extent of the confirmed victims. The Melfort Detachment had already arranged for door to door searches to be conducted for additional victim's/crime scenes and reported back to MCU upon completion. This was done in conjunction with the ERT Team. Further open area searches for victims were conducted with drones.

MCU initially used the Melfort RCMP Detachment to store exhibits; however, its capacity became quickly overwhelmed by the amount of seized items. Exhibit storage was eventually transferred to the District Support Services Building in Prince Albert and finally to the MCU Exhibit Storage Room in Saskatoon. There were ***nearly 700 exhibits seized*** as part of this investigation.

Normal practice for police is to have as few members as possible seizing exhibits. This lessens the strain on proving proper continuity for key exhibits. The fewer hands that touch an exhibit the less articulation is required to prove the exhibit has not been tampered with. For this reason, in a typical homicide investigation, there will be one identified member tasked with seizing exhibits.

There were ***over 40 separate crimes scenes*** including buildings and vehicles in the JSCN and Weldon. The number of scenes did not directly relate to the number of victims. If victims moved from one point to another after being injured, the number of scenes increased and became more complex. There was evidence that the suspect was driving a number of different vehicles which also increased the number significantly. To add to the complexity, some of the scenes were a significant distance apart. As such, ***tasking only one member with seizing exhibits was not an option***.

A decision was ultimately made by the MCU Exhibit Coordinator that, if there was no MCU crime scene manager at the scene, FIS was to seize all exhibits and turn them over to a the MCU crime scene manager. When Bloodstain Pattern Analysis (BPA) became involved, they seized their own exhibits as well. Given the number of seized items, exhibit management became very time consuming.

Recommendation 4.4 – Explore the possibility of leveraging civilian resources to support the processing of high volume exhibits. Have someone permanently at the exhibit room receiving exhibits.

RCMP Forensic Lab Services:

National Forensic Laboratory Services (NFLS) is part of a single public laboratory system with three sites located in Ottawa, Edmonton and Surrey.

With respect to the forensic lab submissions specific to the JSCN/Weldon event, the MCU Team discussed the most relevant exhibits and, based on circumstances, decided what was to be sent to Forensic Lab Services (FLS), for analysis. The Edmonton FLS was utilized in this case. Investigators generated a document, sequentially listing the proposed exhibits, along with the requested analysis by the MCU Team. This document was sent to the lab and was ultimately declined as it was not in the standard C-414 document format. This resulted in the crime scene management team's perception of FLS process delaying submission.

To understand the method of submitting lab exhibits, one must also consider the protocol that FLS must go through when they receive a request. From the FLS perspective, the C-414 is a standardized form that contains all of the necessary fields of information that FLS requires to begin processing. The use of this standardized form permits streamlining and ensures consistency and effective exhibit processing for case submissions. Further, it is a form that is used many different units throughout the lab as the case progresses, and is used by laboratory staff at many stages throughout the process. If, in a situation such as the JSCN event, FLS was to accept a 'non-standardized' form there is a real possibility that communication would have to occur after the fact, between the Forensic Assessment Centre (FAC) Strategist and the investigator for further clarification. Further, the information contained in the C-414, when received by FLS, has to be manually inputted into another system by the strategist, which is also time consuming.

There is an understanding from FLS that in this particular case, the requirement of the C-414 was cumbersome and time consuming, considering the events took place in a rural community, and that investigators had limited access to the internet and digital tools that would normally make such a submission easier. Further, given the time required to process the large number of crime scenes and exhibits, and the fact that a large file was shared with event details, this administrative requirement was an additional time and energy burden. For future events of this magnitude, the FAC could agree to support the transfer of information from another document into the C-414 form; however, the draft will need to be reviewed and approved by the investigator prior it being accepted by FAC. This communication would be crucial in order to avoid any information being misrepresented, or left out.

Current FLS practice is such that upon receipt of a lab request from an investigator, the FAC Manager will assemble the appropriate specialists to ensure there is a team approach. ***For future mass casualty events, FLS appreciates the need to bring this internal group together in a timelier fashion*** to ensure an efficient and effective approach for the submission of exhibits. This may require ***additional interaction with investigators*** in order to understand the context of the case and ensure the most probative exhibits and known samples are submitted first and as quickly as possible.

Many of the misconceptions around the process of forwarding exhibits on large, complex events may have been resolved by the ***investigative team and the FAC strategist engaging in early conversations*** regarding the capabilities that FLS had to potentially assist investigators with transferring information from their document to the C-414 format. Had this communication occurred, the investigative team may have continued on with their work and FLS would have been receiving the information in the format they required.

Recommendation 4.5 – Explore opportunities for FLS to lead presentations to MCU to relay the capabilities of their services, particularly in regards to mass casualty events, and to form a basis for discussion between the units.

It is worth noting that as part of their modernization initiatives, the ***NFLS intends to develop an electronic tool that will be less cumbersome*** and more dynamic to use than the current C-414 template. This tool is not yet available for use.

Command Clarity:

Command structure was reviewed in an earlier section of this document; however, it is worth noting, from a MCU perspective, how the CIC, DEOC, and OCC/MOSS roles were viewed. MCU's reporting lines were clear. All information flowed from the MCU CT to the OIC of MCU (Superintendent Josh Graham), who then passed it along to the division managers situated in the DEOC, and ultimately the Commanding Officer of 'F' Division.

Any issues that were noted between the various commanders resulted more from limited communication rather than any uncertainty of command.

Communication:

Due to the number of teams that were tasked out (as noted above in the MCU Org Chart) and the fact that many teams were not in the same geographic location at any given time, the MCU Team was unable to hold regular 'fulsome' briefings. The CT did what it could to debrief with the various 'sub-teams' that were created and all MCU members were kept apprised of the pertinent information they required.

Any areas of concern with communication stemmed from not having a MCU resource embedded or otherwise linked directly to the OCC. To illustrate this point, following the broadcast of the Public Alerts that contained suspect information, there was a large influx of complaints being called in to the OCC regarding potential sightings. During this time, the MCU ***Tips Intake Coordinator*** was situated in the DEOC, not in OCC. It was later discovered that that a number of public tips relating to sightings from the Wakaw area on September 4th and 5th were never forwarded to the tips coordinator, and ultimately to the MCU investigators from the ***Apprehension Team***. MCU investigators held the belief that the DEOC was monitoring/coordinating all of the resources outside of the MCU Investigation, ***including any of the complaints received by OCC***. Since the Tips Intake Coordinator was not monitoring the calls in the first instance being received by OCC, some of the sighting complaints did not make their way to investigators until after the fact.

By this time the CIC was fully engaged in apprehension efforts and were working alongside the MCU member tasked as the ***Apprehension Team*** Leader. An agreed upon communication strategy for CIC and the Apprehension Team was discussed and it was agreed the two entities would have to work closely together as both of their objectives (apprehension) were clearly aligned. The Apprehension Team eventually relocated to another building, which impacted the timeliness of communications and forced them to rely on frequent phone calls. It should be noted that an unrelated ERT deployment happened during this time, which may have rushed the decision to relocate the Apprehension Team and may have overshadowed the need for both to remain in the same location.

Had the ***MCU Apprehension Team*** had knowledge of the incoming tip information as it was received, they could have strategically re-allocated resources. If the Tips Intake Coordinator in the DEOC had an understanding of the how the tips were being handled by the OCC or vice versa, the belief is that there would have been a more seamless transfer of the information. For context, the OCC and DEOC are not physically located in same work space but they are in close proximity within 'F' Division HQ in Regina. Despite this, the two units have little interaction.

The topic of ***Triaging Tips*** will be further discussed in ***the 'Operational Communications'*** section of this report.

Based on the above information, on September 15th the decision was made to complete ***a full audit of all complaints received in Saskatchewan between September 4th and 7th by DCAS***. This audit is on-going.

Forensic Identification Services (FIS) Response:

When a crime is committed or disaster occurs, FIS members are called in to secure, record, and document the scene as well as collect and package exhibits for analysis. Depending on the type of investigation, this may include crime scene photography and sketches, fingerprint, footwear and tire-track examinations, looking for trace evidence, bloodstain pattern analysis, and collecting samples for DNA. The evidence collected is used to identify suspects or victims, and is interpreted and presented in court.

There are more than 70 Forensic Identification Sections (FIS) units across the country, 5 of which are located in Saskatchewan (Regina, Saskatoon, North Battleford, Prince Albert, and Yorkton), that provide Forensic Identification services to RCMP detachments, Canadian police services, and assist National and International organizations in disaster victim identification.

'F' Division FIS units each have a member that is on-call daily, following every shift and in position to field questions from investigators that may be at a scene and respond, when necessary. Further, 'F' Division has at least one member scheduled to work in the office everyday of the year.

Effective Practice:
Having a FIS resource in the office allows for immediate responses to emergent situations.

Specifically relating to the JSCN, once contacted, the on-call FIS member from Prince Albert immediately realized the situation exceeded the capacity for a single FIS unit to deal with and contacted the Division FIS Manager, who was at his residence. The FIS manager had all of the contact information that he required on his phone to make immediate call outs to deploy the other 5 FIS Units in Saskatchewan.

RCMP FIS Units in Saskatchewan

FIS does not always make an immediate response to scenes and does not attend every call. FIS will determine the potential for evidence and the urgency of the scene based on information provided by the first responder to the scene. There are clear instructions (flowchart) as to making a decision whether or not a FIS resource is to attend a scene when contacted. Needless to say, the events that occurred on September 4th received an immediate FIS response when called.

Resourcing:

Naturally, at the onset there were limited FIS resources as other units were in the process of travelling to the area. Prince Albert FIS arrived at the JSCN along with Saskatoon FIS members and were directed to immediately begin processing outdoor scenes where there was a deceased. This was a mindful decision to not only preserve any evidence from the elements but also to avoid the negative perceptions of family members or public viewing the deceased for an extended period of time. As additional FIS members arrived, team leaders were identified and were in charge of each individual scene and were the point of contact for the FIS Manager. Scenes were prioritized as those with deceased persons (outdoor) as the priority, followed by indoor homicide scenes, blood letting scenes, and break and enters. As scenes were completed, the FIS Manager would assign team leads their next assignment.

Ultimately, FIS would be responsible for processing the ***over twenty scenes*** (eight with deceased persons, ten with surviving victims, and four vehicles). Further to this, FIS was required to attend ***ten autopsies*** at various times.

From a resource perspective of what was available in the division, the dispatch of members was deemed adequate. Given the circumstances, more resources are always desired; however, all available FIS resources in the division were drawn in with others being called in, as required after the fact. ***Prince Albert Police Service*** (PAPS) provided 1 FIS member, and ***Bloodstain Pattern Analysis (BPA)*** specialists were called in from outside the division as well (explained later). Resources from Regina FIS were not contacted for assistance as the Division Manager was mindful that, although what was happening on the JSCN and in Weldon demanded a robust response, should another call have come in that FIS was required to attend, he would have access to another FIS Unit. Further, it was anticipated that the various deceased bodies would be transported to either Saskatoon or Regina for autopsies, which ended up being the case. Having an available unit allowed for those FIS resources that were processing scenes, to continue their work.

Effective Practice:
Be mindful of the possibility of another deployment and the need for resources to be made available for the same.

Crime scene security for the various locations was resourced by the DEOC with Saskatchewan Highway Patrol, Saskatchewan Environment Resource Management, 'K' Division members, 'D' Division members, and whatever available resources from 'F' Division were still available. These additional resources were deemed essential for the crime scene management portion as they contributed to the FIS members never feeling pressured to complete a scene examination, allowing them to complete their duties as best they could.

Effective Practice:
Use of support units and Provincial resources for added scene security.

Whenever a major incident such as this occurs, police naturally want to help. In reality, however, not every member can be called in for duty to assist. As mentioned, not all FIS resources were deployed as part of the JSCN and Weldon incident. Some of these resources felt that they may have been overlooked or were wondering if there was some type of negative reason that they were not utilized. The Division Manager was sure to

stay in contact with those units or members that were not brought into the incident and included them in contingency planning and in final briefings.

FIS Equipment:

The circumstances surrounding many of the scenes on the JSCN were such that many family and/or community members were present and remained on scene during the FIS examination. There were many cultural factors at play that members on scene were aware of and did their best to accommodate. These cultural factors will be explained further in the ***Mass Casualty/Victim Response*** section of this review.

Given the fact that there were a number of family and/or community members at each scene, FIS members naturally interacted with them at times. FIS members occasionally had to provide instruction for community members to re-locate further back from crime scenes. For the most part, family and community members complied with no issues; however, there were reports of FIS members being completely exposed to the public, which is not an ideal situation for them to conduct their work. If any contentious issues arose, a member of a ***Family Liaison*** team was usually available to speak with family members regarding forensic integrity and the need to allow FIS members to do their work. In one instance where there was a body lodged between two vehicles. Scene security was asked to reposition their vehicle in order to block the family's view when the blanket tarp was removed. During the course of this review, interactions with JSCN community members revealed some concerns over the amount of time that certain scenes remained visible to on-lookers, which is natural. Ultimately, FIS members did their best to conceal any deceased or evidence that would have upset any non-police that may have been present; however, there may have been instances where exposure was causing unintended strain on those present.

Although tarps were available at all scenes, some type of private enclosure (fabric wall, tent) would have assisted with covering the deceased and also to act as a shelter for the FIS members to relocate to should they have required it while processing outdoor scenes.

Recommendation 4.6 - Consider purchasing inflatable tents or fabric walls for FIS to protect hold back evidence and provide more dignity to the deceased while processing scenes.

The trailer (mobile CP) that was being utilized by other units as a 'home base' was not a feasible option for FIS to use. A larger, on site base would have served as a point of contact for FIS, including a place to display an org chart for members, org charts mapping

out scenes, photos of any physical evidence, or other FIS intelligence/information sharing whether informal or via regular briefings.

Incidents of this magnitude naturally attract attention not only on a divisional level, but nationally as well. The Division FIS Manager made sure to brief his supervisor on a daily basis in order that accurate information can be relayed to those with a vested interest in Ottawa.

Effective Practice:
Providing at minimum, regular unprompted National level daily updates for major events.

Body Removal:

During body removal, everyone in charge of scenes was aware of the possibility of family members wishing to perform cultural ceremonies prior to removal and, when requested to do so, it was facilitated. Family and/or community members were present at most, if not all scenes. There were times that upwards of 60 people were outside of a scene waiting for directions from FIS. FIS members that were processing the various scenes were cognizant of the impact of such an event on the community and were sensitive to the needs of the community in allowing these ceremonies to take place, despite delaying the examination process. The FIS members at some of these scenes experienced difficulties where vehicles were community members were present. There were times when FIS were fully exposed to victims' families, who were sensitive about FIS members touching or moving the bodies during the scene examination. These types of issues were mitigated when ***Family Liaison Team members*** assigned to the various victim families, were able to provide communication that balanced the investigative need for forensic integrity and the need for victim families to perform cultural ceremonies on their loved ones. Following the processing of scenes, any family member requesting time with the deceased were granted whatever time they required.

Body removal was done as quickly as it could have been given the circumstances. Two coroners eventually attended each scene and the queue was significant given the number of scenes. Naturally, it would have expedited removal had there been more coroners available. Efforts were made by the Coroner's Office to streamline their attendance at scenes and they eventually split their teams in an attempt to expedite the process.

Bloodstain Pattern Analysis (BPA):

Requesting BPA resources attend any given scene is a decision that is made only after a FIS member has attended the scene and, in conjunction with the investigator on scene, determines if BPA analysis would aid the investigation. BPA can provide input and opinion on scene examinations, exhibit examination, consultation on scenes and exhibits, training sessions on BPA, and case photo review and analysis.

BPA can contribute to crime scene examinations regarding the location and description of individual stains and patterns, mechanism(s) that created the stains, direction a blood droplet was traveling, area of origin (location of blow into blood source), type of object used in attack (edged, blunt, firearm, etc.), minimum number of blows, presence of a subject at a scene - linking suspects, victims and objects, location of the victim, perpetrator, and objects during events and their movements, and the sequence of events. BPA was reached out to for assistance due to the significant amount of blood letting at the various scenes.

BPA members are located in British Columbia ('E' Division), Alberta ('K' Division), and Nova Scotia ('H' Division). The Edmonton BPA resources responded from 'K' Division. The Edmonton BPA section is located in the RCMP Forensic Laboratory in Edmonton and provides 24 hour services to K, F, D, G (NWT), part of V (Nunavut) Divisions along with other police agencies in Alberta, Saskatchewan, and Manitoba. BPA sections are now divisional supplements, whereas they used to be national. 'K' Division led the BPA response to the JSCN. In total there were ***2 BPA resources utilized from 'K' Division and 1 from 'E' Division.***

Specifically, in relation to the JSCN, 'K' Division BPA was contacted in the early afternoon of September 4th by a FIS member that was on scene at the JSCN. This is a normal process whereby an attending FIS member will contact BPA to determine whether BPA assistance would be beneficial. At that time, the BPA member requested photos of the scenes they were being consulted on in order to make a determination of whether to attend. After it was ascertained that attendance was necessary, by 10:00 pm that night, BPA was of the understanding that they would be ***attending to process 5 scenes*** and plans were made to depart the following morning from Edmonton. The Edmonton BPA resource had access to an understudy and was confident that processing the 5 scenes was not unrealistic and thus, did not call any additional resources at that time. BPA arrived the following day and were advised that there was now a ***requirement to process all of***

the scenes. It was at this time that another BPA resource would be required and one was secured from 'E' Division.

The communication and teamwork amongst the various units when it came to processing the scenes was excellent according to BPA resources. The time that it took to properly process the various scenes was done as quickly as it could have, partially due to the attending FIS members' ability to identify blood staining for further analysis by BPA, prior to arrival. This recognition may have been in part, due to obtaining appropriate training in basic bloodstain pattern recognition. When FIS employees obtain this entry level training, it provides an increased level of awareness and ability to determine whether a BPA is warranted, the best method for recording bloodstain evidence for remote BPA support, and for assessing bloodletting scenes and consulting with a BPA member:

This training used to be mandatory; however, is no longer. Further, this course is a pre-requisite to becoming a certified BPA analyst which can be a 12-18 month long process through the BPA Program.

Recommendation 4.7 – Consider making the Basic Bloodstain Pattern Recognition Course mandatory for all FIS members.

Resourcing of BPA positions was noted to have been an issue across the country. There are simply not enough BPA resources to draw from in the event something like the JSCN/Weldon event were to occur again. As pointed out above, many of the divisions do not have BPA resources and even if all the positions were filled, they would still be short for the amount of work that BPA is being asked to do.

One avenue to mitigating the shortage of BPA positions could be to look beyond Regular Members and to consider civilians assuming some of these roles if qualified to do so. The ***Integrated Forensic Identification Services (IFIS)*** supports Forensic Identification Services (FIS) employees and includes FIS specialists, as well as ***civilian forensic assistants***, forensic scientists, policy makers, and administrative staff. Only FIS members certified by the Director, IFIS, as Bloodstain Pattern Analysts can interpret and report opinions on bloodstain evidence.

Recommendation 4.8 – Nationally, FIS should explore the feasibility of 'civilianizing' some BPA positions in order to alleviate some of the resource strains.

Strategic Communications

In the midst of a mass casualty event such as what occurred at the JSCN and Weldon on September 4th, critical communication to those affected, serves to either assist in managing the situation or can create further confusion surrounding it. An effective communication plan is essential during these events.

As will be outlined throughout this section, the method by which the RCMP released information was completed is such a manner that connections were made with the public without compromising the on-going investigation. The strategic communication that occurred in regards to the JSCN and Weldon was done through the 'F' Division Media Relations unit out of Regina. Keeping the communications strategy local (to the Melfort Detachment) was never considered, as the situation on the JSCN and Weldon was immediately identified as a public safety concern that would generate provincial and national attention.

Media Relations played a lead role in the issuance of the various public alerts that were a major contributor (along with social media) in keeping the general public apprised of the province-wide situation that was evolving from the JSCN and Weldon on September 4th and the days that followed.

About Media Relations:

'F' Division Media Relations are staffed with seven employees who fulfill a variety of roles. Among these are managing social media, writing/assisting with news releases, internal messages to staff, and writing/issuing the public alert messages for significant incidents. The Media Relations unit and their strategic communications team fall under 'F' Division's Operations Strategy Branch (OSB).

About Operations Strategy Branch (OSB):

OSB supports RCMP operations by ensuring that the Division is a strategically focused, aligned, and intelligence-led. The role of OSB is to coordinate client service and strategic relationships, oversee business planning, coordinate business cases, provide business intelligence and research, facilitate integrated risk management, and manage continuous improvement throughout the division.

Initial Call and issuing the Public Alerts:

To briefly re-visit the 'Initial Response' section above, the initial 911 call in relation to the JSCN was dispatched to the Melfort RCMP members at 5:43 am. Members departed Melfort at 5:52 am, travelled to the JSCN, and arrived at the first scene at 6:20 am.

The Media Relations Officers (MRO) staff began receiving notifications regarding JSCN at approximately 6:30 am of September 4th and immediately determined that a SaskAlert (Public Alert) was required based on the circumstances at that time. In the following 20 minutes, urgent calls were made between MRO resources and arrangements for both the technology to issue the Public Alert's and the wording for the alert were in the process of being completed. It should be noted that all MRO resources (even those that were not on call) had their laptops at home and had the ability to remotely access the National Alert Aggregation and Dissemination (explained below) that is required to issue the Public Alert. While preparations for the Public Alert were underway, the MRO was being informed of the numerous emergency calls that were into the OCC.

By 7:00 am the Duty Officer, Inspector Chamberlin, had granted approval to issue the initial Public Alert.

Effective Practice:
OCC alerted RCMP members of the Public Alert prior to it being disseminated in the event they were in a compromised position (i.e. hiding or about to engage a suspect)

At 7:12 am, the first Public Alert message was issued to the areas of ***JSCN, Melfort, and Humboldt areas at 7:12 am*** was as follows:

The message ***'A Dangerous Persons Alert is being issued by the Melfort RCMP after several calls of stabbings on the James Smith Cree Nation. Saskatchewan RCMP are responding and trying to locate two male suspects. If in the area, seek immediate shelter/shelter in place. Use caution allowing others into your residence. Do not leave a secure location. DO NOT APPROACH suspicious persons. Do not pick up hitch hikers. Report suspicious persons, emergencies or info to 911. Do not disclose police locations.'***

For clarity, ***SaskAlert*** is the Government of Saskatchewan's emergency public alerting program that provides critical information on emergencies in real time, so the public can take action to protect themselves.

Media Relations obtained the information they required to meet the threshold for a public alert almost immediately, which allowed for a quick approval of the planned messaging to the public. The communication between the MRO and the strategist who had the ability to input data into the ***National Alert Aggregation and Dissemination (NAAD) System*** was swift and efficient. The initial public alert was broadcast as quickly as it could have been.

The ***NAAD System*** provides the technical infrastructure of Canada's national public alerting system. The NAAD system accepts emergency alerts from Authorized Government Agencies (SaskAlert) which are then made available to broadcasters and other media distributors who voluntarily distribute them to the Canadian public. The NAAD System is not user friendly as those who are familiar with the system pointed out during the course of this review. The system was created for weather alerts but had been modified to suit other types of alerts.

The speed at which it was broadcast can be attributed to having practiced issuing public alerts. Strat Comms conducted quarterly training with Incident Commanders, Detachment Commanders, CIC, and CROPS Officers in order to create a shared ownership and promote an understanding of emergency alerting in the province. It should be noted that both the MRO and the media strategist that inputted the data in the NAAD System had their computers at their homes which enabled them to further expedite the timeliness of the initial public alert.

Recommendation 5.1 – 'F' Division should support any potential system updates that may promote efficiency and continue to identify any methods to streamline the process of data input into the NAAD System.

Effective Practice:
Regular practice sessions with Senior Officers dealing with issuing public alerts as per RCMP Policy.

Once resources were present in their workspaces at RCMP Headquarters in Regina, the MRO was able to task unit resources more efficiently. Tasking included, but was not limited to, social media, completing the public alerts, completing media releases, and generating speaking notes for the Commanding Officer. To offer some perspective, over the course of the four days (September 4th – 7th), the Media Relations Unit received more than 550 requests from various media outlets. It was deemed to be chaotic, but manageable.

Effective Practice:
A specified Media employee was tasked with answering the media phone line and tracking the media calls. This gave reporters the ability to speak to an actual person, rather than a listen to a recording during the event.

There appeared to be frequent communication between the investigative team (MCU) and the Strat Comms unit that were embedded directly in the DEOC, in Regina. This created a link to the investigation in terms of acquiring pertinent and timely information and, in the view of Strat Comms, diminished the need to have a media advisor embedded in the command post, alongside MCU. From the MCU perspective, it would have been useful to have that immediate communication with Strat Comms working in tandem, at the same location. Given the fact there was efficient flow of communication between MCU and Strat Comms, the physical location of the resources did not have an effect any of related outcomes.

Aside from the initial Public Alert, MCU was consulted thoroughly on all others prior to their broadcast. There was a significant amount of communication between MCU and Strat Comms throughout the investigation with respect to what information could be broadcast to the public and the effect that it may have on the investigation. The only instance where released information had a direct impact on MCU resources will be addressed later in the Mass Casualty/Victim Response section, when the ***Family Liaison*** teams were unable to notify the victims' families of the positive identification of the suspect's brother on September 5th, prior to the release of the information to the media.

Subsequent Public Alerts:

September 4th at 7:57 am – *Update for the Dangerous Person Alert issued by the Melfort RCMP for multiple stabbings on James Smith Cree Nation. Suspects are Damien Sanderson and Myles Sanderson. Damien Sanderson is 5'7" and 155 pounds with black hair and brown eyes. Myles Sanderson is 6'1" and 200 pounds with black hair and brown eyes. The suspects may be in Black Nissan Rogue with SK license plate 119 MPI. If in the area, seek immediate shelter/shelter in place. Use caution allowing others into your residence. Do not leave a secure location. DO NOT APPROACH suspicious persons. Do not pick up hitch hikers. Report suspicious persons, emergencies or information to 911. Do not disclose police locations.*

Note: Included in the Public Alert (above) issued 7:57 am was an incorrect photo of Myles Sanderson. Once the suspect(s) were identified, a media specialist conducted database

checks in an effort to obtain a photograph to accompany the media release to assist the public with identifying/locating the suspects so they can take suitable measures to protect themselves. There were two subjects contained in the database with the same name (Myles Sanderson), with an age difference of 5 years, and both from JSCN. During an extremely dynamic situation with frequent updates the media specialist chose the incorrect photo, initially. Of note, the subject of the incorrect photo had the more recent, documented activity on JSCN. Once aware of the erroneous photo, Strat Comms immediately replaced it with a correct one and steps were taken to remove the photo from the Public Alert system as well as any on-line photos.

September 4th at 8:20 am *– Update for the Dangerous Person Alert issued by the Melfort RCMP for multiple stabbings on James Smith Cree Nation. Suspects are Damien Sanderson and Myles Sanderson. Damien Sanderson is 5'7" and 155 pounds with black hair and brown eyes. Myles Sanderson is 6'1" and 200 pounds with black hair and brown eyes. The suspects may be in Black Nissan Rogue with SK license plate 119 MPI.*

September 4th at 10:01 am *- Update 4: there are multiple victims, multiple locations, including James Smith Cree Nation and Weldon. Early indications may be that victims are attacked randomly. Suspects: Damien Sanderson and Myles Sanderson. Damien is 5 foot 7 and 155 lbs with black hair, brown eyes. Myles is 6 foot 1 and 240 lbs with brown hair and eyes.* ***See new photo****. This is a rapidly-unfolding situation. We urge the public to take appropriate precautions. Do not leave a secure location. Use caution allowing others into your residence. DO NOT APPROACH suspicious persons. Do not pick up hitch hikers. Report emergencies or info to 911.*

September 4th at 12:07 pm *– Update 5: SK RCMP received a report the suspects may be traveling in the Arcola Ave area around 11:45 a.m. in Regina, SK in a black, Nissan Rogue with SK license 119 MPI.*

If in the Regina area, take precautions and consider sheltering in place. Do not leave a secure location. Use caution allowing others into your residence. DO NOT APPROACH suspicious persons. Do not pick up hitch hikers. Report suspicious persons, emergencies or info to 911. Do not disclose police locations.

September 4th at 12:19 pm (Alberta) *- A RCMP alert is being extended to Manitoba and Alberta. A Dangerous Person Alert is in place after multiple stabbing incidents reported September 4 in multiple locations, including James Smith Cree Nation and Weldon, Saskatchewan. Two male suspects may be traveling in a Black Nissan Rogue, Saskatchewan license 119 MPI.*

September 4th at 1:28 pm (Manitoba) *- SK RCMP issued a Dangerous Person Alert after multiple stabbing incidents reported September 4 in multiple locations, including James Smith Cree Nation and Weldon, SK. Two male suspects may be traveling in a Black Nissan Rogue with SK license 119 MPI. Whereabouts are unknown and alert is being extended to AB and MB.*

The public should take appropriate precautions. Do not approach suspicious persons and report any information to your local police and emergencies to 911

September 5th at 11:39 am *- Update 6: The Dangerous Person Alert issued by Sask RCMP on September 4 for multiple fatal stabbing incidents with multiple locations continues. The two adult male suspects continue to be at large and have not been located/direction of travel is unknown. Suspects may be travelling in a black, Nissan Rogue with SK license 1 1 9 M P I.*

Remain vigilant and take precautions. DO NOT APPROACH suspicious persons. Do not pick up hitch hikers. Report suspicious persons, emergencies or info to 911. Do not disclose police locations.

September 5th at 4:35 pm *- Update 7: Update for the Dangerous Person Alert issued by the Melfort RCMP for multiple stabbings. Damien Sanderson has been located deceased. Saskatchewan RCMP continues to search for Myles Sanderson, who is 6 foot one inch and 240 pounds with black hair and brown eyes. He may be injured and seek medical attention. He may be in a Black Nissan Rogue with SK license plate 119 MPI. It's unknown if he's travelling with anyone.*

The public should take appropriate precautions. Do not approach suspicious persons and report any information to your local police and emergencies to 911.

September 6th at 11:40 am *- Update 8: Update for the Dangerous Person Alert issued by the Melfort RCMP for multiple fatal stabbings. Investigators have received reports of a possible sighting of suspect Myles Sanderson in James Smith Cree Nation. RCMP are responding. If in the area, seek immediate shelter/shelter in place. Use caution allowing others into your residence. Do not leave a secure location. DO NOT APPROACH suspicious persons. Do not pick up hitch hikers. Report suspicious persons, emergencies or info to 911. Do not disclose police locations.*

September 6th at 2:56 pm *- Update 9 for the Dangerous Person Alert issued by the Melfort RCMP for multiple fatal stabbings. Further investigation has determined that Myles Sanderson is not located in the community of James Smith Cree Nation and the RCMP continues to search for him. As his whereabouts remain unknown, we urge the public to take appropriate precautions.*

Do not approach suspicious persons and report any information to your local police and emergencies to 911.

***September 7th at 2:39 pm** - Update for the Dangerous Person Alert issued by the Melfort RCMP for multiple fatal stabbings.*

Myles Sanderson is charged with multiple counts of first degree murder. He has NOT been located. Myles is 6 foot one-inch-tall and 240 pounds with black hair and brown eyes. He may be injured and seek medical attention. The Black Nissan Rogue with Saskatchewan license 119 MPI has NOT been located. The emergency alert remains in effect and we ask the public to remain vigilant. If heightened risk to public safety is identified, further emergency alerts will be issued. Investigational updates will be posted to rcmp-grc.gc.ca/en/sk as they become available.

***September 7th at 2:49 pm** - Individual reported to be armed with a knife is traveling in a 2008 White Chevrolet Avalanche, Saskatchewan license 953 LPL that was reported stolen out of Wakaw around 2:10 p.m. today. Last seen traveling in Wakaw on Cemetery Road. Their direction of travel is unknown. Unknown persons involved. We believe this may be related to the Melfort dangerous person alert issued Sunday Sept 4. in the Wakaw area, seek immediate shelter/shelter in place. Use caution allowing others into your residence. Do not leave a secure location. DO NOT APPROACH suspicious persons. Do not pick up hitch hikers. Report suspicious persons, emergencies or info to 911. Do not disclose police locations.*

***September 7th at 3:50 pm** - CANCELLED - Dangerous Persons Alert issued by Melfort RCMP: Myles Sanderson was located and taken into police custody near Rosthern, SK at approximately 3:30 p.m. today. There is no longer a risk to public safety relating to this investigation. As updates become available, they will be posted to the Saskatchewan RCMP website: www.rcmp-grc.gc.ca/en/sk*

Perceived Value of Public Alerts:

From those subjects that were interviewed (both police and public), the overwhelming view was that the ***public alerts were effective*** as they relayed important safety information to the public, quickly. Having said this, there were also reports of some people ignoring the alerts or having not received them due to not having a cell phone. As such, every alert that was issued was also sent out as a news release and posted on Facebook to enable the public's ability to obtain the information from multiple sources. Post event, there was discussion surrounding the extension of some of the Public Alerts to Alberta and Manitoba; however, it was deemed as justified, since the suspects remained

at large and there was information that they were on the TransCanada Highway and could have been travelling in any direction.

There is little dispute that the Public Alerts that were issued were of considerable value. The majority of those interviewed agreed with the number and content of the alerts. Nevertheless, the natural consequence of alerting those involved in such a tragic and evolving event is that there was potential for a negative impact to survivors and victim families with the ongoing alerting and the jarring sound that notifies the public to them. Despite this, the value in the Public Alerts was recognized in the JSCN community; however, some believed that First Nations Communities should have their own Alert System due to the unique geographic and local needs and issues.

Whatever the circumstance there will always be a balance between the need to inform the public for safety reasons and informing the public to simply to provide an update. If only to provide an update to the public, consideration could be made to utilize Victim Liaison Teams to relay information to the affected families first, prior to an alert being.

Social Media:

We live in a world where an increasing amount of people rely on social media as their primary news source. Many expect to find breaking news first, on social media. Additionally, social media content tends to shape narratives and impact perceptions of their users. Notwithstanding, this can have both positive and negative effects however. Regardless of its perceived worth, social media has become an important means for sharing urgent news and updates with the public.

Specifically, in relation to the JSCN/Weldon event, Strat Comms staff posted all updates to social media feeds. These feeds were initially believed to have been a ***secondary way of informing the public*** about the critical events that were unfolding. Social media did however, become more ***important as time wore on***. Once the investigation was at the point of simply sharing information or updates, social media and news releases became the primary means of reporting. Press conferences were livestreamed on Facebook and shared a link to the livestream could be found on Twitter as well.

As a means of receiving information from the public via social media, despite comments being turned off on Facebook, the public still had the ability to send private messages if they wished. 'K' Division resources were prepared to assist with monitoring the Facebook in-box; however, there were so few messages, they were able to monitored in house.

The JSCN has a Community Facebook page that was re-posting the various RCMP updates. This method of relaying information was noted to have been an effective way to reach the community with accurate information. Conversely, however, speculative or unofficial updates were also posted on Facebook by community members that were sometimes inaccurate and caused confusion. This point was brought up when interviewing some of the JSCN community members where there was a suggestion that there could have been a dedicated member of the community tasked with providing accurate information on their Facebook page.

Senior Leadership:

The Commanding Officer, Assistant Commissioner (CO) Rhonda Blackmore, was the primary RCMP spokesperson and became the face of the RCMP response to the JSCN/Weldon event. The CO was engaged at the onset of the event and attended regular briefings which led to her being well versed with real time information that could be relayed. CO Blackmore advocated for transparency early on and this tone was expressed in her media availabilities. Examples of this transparency could be seen when it was announced early on that the suspect's brother was no longer being considered culpable in the multiple murders and the continual updates that were provided as to the number of the casualties. Updates from the RCMP generally do not occur as quickly as they did during this event and they were noted by RCMP membership and by extension the public, as timely and needed.

The primary focus for media interviews was to provide local TV, radio, and newspaper availability first, followed by national media interests. The CO appeared nationally on CTV National News and CBC's 'The National' and always made herself available for interviews and to provide updates. A large portion of the CO's workday was dedicated to media in order to ensure the public could stay informed.

Effective Practice:
Having the CO taking responsibility of the media portions and had well planned media strategy.

Local media requests were given precedence for providing interviews over non-regional or international media.

Recommendation from MacNeil Report (Moncton 2014):
8.3 It is recommended that news conferences in these types of incidents should have a spokesperson presenting the operational perspective of the investigation to reassure the community that police are taking action.

Communication:

Strat Comms representatives were involved in all briefings and meetings from the beginning, throughout, and following the JSCN/Weldon event. This communication allowed media relations staff to deliver informed, clear, timely, and transparent messaging to the public.

Communication with the Government of Saskatchewan occurred very quickly. By 7:07 am on September 4th, the Assistant Deputy Minister of Policing and Community Safety Services was notified of the situation and was kept apprised. Further calls were made to senior leadership, the MOSS Unit, and FSIN.

Outside police agencies were communicated with appropriately. As news was received, for example, on September 4th that the suspect vehicle was believed to be in Regina, RPS was notified immediately of the situation and further, that a Public Alert specific to Regina was being issued. Although this information was never confirmed (as was discussed earlier), the communication flowed easily between agencies in large due to the pre-existing relationship between the Director of Media Relations for the RCMP and that of RPS Communications Director. This network further promoted brainstorming sessions amongst media strategists that further led to a consistency of information flow from the scene to Regina, as information was received.

Effective Practice:
Establish media relationships with various municipal agencies in the event that collaboration is required.

Outside divisions were reached out to where 'D' Division (Manitoba), 'K' Division (Alberta), and National Communications Services were contacted for assistance if required. 'D' Division and National Communications Services each sent one communications resource to assist and 'K' Division was prepared to provide help in terms of monitoring social media if required.

Effective Practice:
Continued liaising with municipal counterparts and in other divisions in order to expedite assistance in times of critical need.

Summary:

Whenever police are confronted with responding to a situation where an individual that has committed violent crimes has fled and there is a distinct possibility that they may cause further harm to the public, there will generally be an analysis into the type and

amount of police communication with the public throughout. In these situations, police have the difficult task of balancing the requirement for the public to know pertinent information in order to keep them safe with the potential of jeopardizing apprehension efforts and the ensuing criminal investigation.

These situations are unique and it would be unjust to compare specific details amongst various events from the past. That being said, there are generalities such as clear policies, planning, and training that should be considered commonplace in all responses.

The early communication between the Duty Officer and the Media Relations Officer (MRO) and the recognition of the requirement to disseminate information to the public early on, provided the basis for the public being well-informed for the duration of the JSCN/Weldon event.

Once the authority to issue the initial public alert was provided, the MRO became immediately entrenched alongside those in command and was a permanent fixture in the Incident Command Post. From that moment onward, public communications were fully integrated into critical incident response and the training scenarios that had been completed prior to this incident became readily apparent and should be seen as evidence of growth from past mass casualty events.

Operational Communications

Depending on the type of emergency, location, and time of day, an Operations Communication Center (OCC) can be inundated with calls about an emergency. The massive influx of related calls can be overwhelming depending on the number and experience of the dispatchers on duty.

Dispatchers in an OCC play a critical role in managing emergency incident communications not only from the initial dispatch, but throughout the duration of an event. A well-trained, experienced dispatcher should be viewed as a critical component of the overall response team.

This section of the report will focus on the actions taken by the 'F' Division OCC and their role in the response to the mass casualty event at the JSCN and Weldon.

About 'F' Division OCC:

Located at the 'F' Division HQ in Regina, the OCC receives over a ***quarter million-calls for service per year*** from the public. OCC provides assistance and works in conjunction with the nearly 1200 police officers in close to 100 detachments and units throughout Saskatchewan. Each OCC shift provides support to the three 'F' Division Districts with a staff of between 6 and 12 operators.

The four OCC teams are designed to be staffed with 12 operators and 2 supervisors per team. Due to current staffing shortages these numbers may be lower from shift to shift. Through attrition, the OCC lost 12 people in 2022 which has contributed to 15 current vacancies that existed at the time of this review. The primary reason identified for those that have left the OCC is pay. The RCMP OCC is paid considerably less than their municipal counterparts (in Regina Police Service for example) where an operator can be paid upwards of $30,000/year more. Further, there are eight bilingual positions with only one, currently being filled. Presently, the OCC has seven 'term contracts' that will eventually fill some of the vacant positions once they have completed their yearlong training.

OCC has taken steps to garner public interest in becoming an operator by taking part in recruiting fairs and social media blitzes; however, the process takes time and there is no immediate remedy to the resource shortage.

Resourcing related to this incident:

The initial calls related to the JSCN started to come into the OCC around 5:40 am, which is the back end of the night shift portion of the schedule in OCC. In general, night shifts tend to be slower so there was a lighter compliment of resources on shift; however, by 6:00 am there were three 'call takers' and two 'dispatchers' working which was normal. By 7:00 am the dayshift resources were coming in and were able to assist with the increase in call volume.

During the 24 hours following the time of the initial call alerting police to the JSCN, the ***OCC took approximately 2600 calls, whereas a normal call volume during this same time period would have been approximately 500.***

The OCC manager, supervisor, and senior managers were all called in between 6:00 am and 7:00 am on the morning on September 4th and were assisting with taking calls to offset the requirement for more dispatchers. This was not an ideal situation as the time being put in to dispatching was taking away from supervisory responsibilities; however, the immediate need to field calls was viewed as more important at that time. Shortly after, additional OCC resources were called in.

OCC operators were in the position where they had to deal with a number of issues in real time with complainants on the line. OCC operators were directing complainants to leave whatever scene they were calling from and go to the band office for their own safety. There was obvious concern from complainants about waiting for the police to arrive at the various scenes and the OCC operators did their best to relay the message that that there were multiple scenes and that members were responding to and they were not able to attend all, simultaneously. Further, the ability to locate addresses on the JSCN proved to be challenging due to house numbers and street names not being clear to both the call taker and/or the complainant.

Throughout the days that followed, dispatchers stayed beyond their scheduled shifts and sacrificed breaks to compensate for the resource shortages and to ensure that any information from previous shift(s) could be relayed appropriately to those taking over.

Specifically, on September 7th, OCC requested and received relief OCC workers as this was an extremely busy day. As a way to mitigate the shortages, the two zones (North and South) were combined and additional operators were called in on overtime. There were a total of ten operators for the remainder of the shift. Further to divisional resources, exploring the possibility of utilizing RPS operators may be considered during major incidents to ease the pressure of staffing shortages.

OCC was also relied upon to call out additional units when requested that resulted in having to shift focus away from the high number of incoming calls that required attention. The ***Everbridge System*** was identified as an alternative for some call out procedures. Everbridge is a ***mass notification system*** that sends alerts to employees that have generated user profiles. New recruits entering Depot generate profiles and utilize this system should there be an emergency while in training. This results is the ability for members to receive the most up-to-date information possible if an emergency were to occur. Using the Everbridge system for various unit call outs for future major events could alleviate some of the pressures that were experienced by the OCC during the JSCN/Weldon event.

Triaging Calls:

As was discussed earlier in the review of the tactics and response to the initial call, the process by which 911 calls are dispatched in Saskatchewan begins with the call going to one of three Public Safety Answering Point's (PSAP) in either Regina, Saskatoon, or Prince Albert. From that point, calls were directed to either police, fire, or EMS. Regina and Saskatoon dispatch generally deal with 911 calls inside their respective city limits, whereas the rural 911 calls (and those in relation to the JSCN and Weldon) are dealt with in Prince Albert. The Regina and/or Saskatoon dispatch centers may have forwarded a small number of 911 calls to the OCC in the event that a 911 caller was on hold for too long with the Prince Albert dispatch, but the majority that came in to the OCC, were coming from Prince Albert.

As mentioned earlier, OCC operator duties are broken down from shift to shift as being either a 'call taker' or a 'dispatcher'. OCC operators are trained in both call taking and dispatching. The duties are self-explanatory where the call taker will obtain pertinent information from the caller to be forwarded to the dispatcher. The dispatcher then contacts a member within the relating jurisdiction, forwards the information, and the member ultimately responds.

One of the gaps in the training for OCC operators was noted when an evaluation of how (and what) information from the public was being requested by the call takers. Operators are currently taught to obtain as much information as possible prior to ending a call. In an emergent situation such as the one that was developing on the JSCN, training does not cover the need for an Operator to potentially end or place a call on hold once the important details have been obtained, in order to allow the Operator to take other potentially more urgent calls in the queue. From 5:40 am (when the first call regarding the JSCN was received) to 7:12 am (when the first public alert was broadcast) there were (36) 911 calls directly related to the stabbings that were occurring, that were received by

the OCC. Thirteen of these calls identified suspects, and two identified a suspect vehicle.

Recommendation 6.1 - If not included in formal training, any 'in-house' training sessions or briefings should highlight the potential issue of staying on the phone longer than necessary in an emergent situation where OCC is experiencing a high volume of calls.

As 911 calls were received by OCC regarding the JSCN and/or Weldon, Melfort detachment members were being dispatched and a separate file was generated for each complaint. These calls, however, did not necessarily follow the actual chronology of events occurring on JSCN as there are typically delays between the specific event and the time the complainants made the call. These sequential issues combined with the possibility of duplicate calls for singular events made it difficult for the OCC operators to ascertain exactly what was going on at the time. In hindsight one can more easily formulate an idea of what the police were responding to; however, in the moment this was understandably much more difficult.

When the resources in the OCC realized the extent of what they were dispatching members to respond to, steps were taken 'in house' to triage calls as best as possible. The OCC operator who had taken the original 911 call was tasked with dealing specifically with calls related to the JSCN and Weldon.

Effective Practice: Promptly assigning an operator specifically tasked to manage calls related to JSCN and Weldon, while others in the OCC were tasked with any unrelated calls in their geographic areas of responsibility.

The specific operator that was dealing with the JSCN also had experience as a supervisor and was one of the more knowledgeable operators in the OCC at the time.

Following the initial calls (911 or otherwise) on the morning of September 4th relating specifically to injured or deceased victims, the nature of calls changed. Once information was being received as to possible suspect(s) and their whereabouts, Public Alerts were being broadcast. As mentioned, the initial Public Alert was issued at 7:12 am and from that point onward there was another influx of calls coming into the OCC in relation to possible sightings of the suspect(s). Call volume increased from an ***average of approximately 500 calls to around 2600***. With this increase also came a marked increase in the public calling in simply to vent frustrations or to offer their various opinions on what was occurring. Further, there was an unrelated Public Alert that was broadcast on September 5th, regarding incidents in Shellbrook and Onion Lake that ended up

confusing the public and the call volume again, increased for the OCC. Although these incidents could not have been foreseen and in no way diminishes the value of forwarding pertinent information to the public, it should be mentioned as the OCC resources were left having to deal with it.

During this 'transition' in the nature of calls from the public there were a number of logistical and command decisions being made that affected the way information was being handled. The DEOC was being activated; CIC was becoming involved; and MCU was engaged. As pointed out earlier, MCU created an Apprehension Team dedicated to finding and arresting the suspect(s).

During the unfolding event, the MCU understanding was that all information being received (tips or otherwise) by OCC was to travel through them, in order that their dedicated resources (Apprehension Team) be kept apprised of the most recent and reliable information, and deployed accordingly. For a period of time; however, the OCC was seemingly unaware of the creation of the Apprehension Team and was continuing with the standard practice of dispatching members and creating files.

Effective Practice: Even during times of significant increases in call volumes, despite that the length of times on calls might have been reduced in the circumstances, the OCC call takers and dispatchers continued to take complaints and dispatch calls for service to the appropriate areas of responsibility, i.e. Detachments of jurisdiction.

This unfamiliarity caused some disruptions of the supposed flow of information to MCU and ultimately, the Apprehension Team. Specifically, there were 'suspect sightings' near the community of Wakaw during the afternoon and evening of September 4th (reference photo in ***'Chronology of Events – Highway 41 Sightings'***) that were not forwarded to MCU from the OCC. Subsequently, these calls (sightings) proved to be significant as one of the callers knew the suspect personally. Having said this, the caller did not relay the existence of the personal relationship to the OCC operator at the time of the call and this fact was only discovered later, when the caller was interviewed by MCU.

OCC supervisors were aware of all 911 related calls regarding possible suspect sightings through an Excel spreadsheet that was generated to track them. Communication between those supervisors and MCU (and ultimately the Apprehension Team) could have served as the link to ensure the information was forwarded to the proper unit and would have diminished confusion surrounding the tip information.

Recommendation 6.2 – At minimum, in the case of a major incident where higher call volumes will be received in the OCC, assign a MCU Investigator, an Analyst,

and an OCC Supervisor to monitor and analyze the incoming calls in real time, to best identify and determine trends, patterns, or clusters of calls that might otherwise not be identified in isolation.

Some of the above communication lapses may have been lessened if there were a closer link between the DEOC and the OCC. Although physically located in close proximity, there was an apparent information sharing gap between the two units. The DEOC, as was outlined in earlier in the review of the Command Structure, acted as the 'hub' of information, as it was being received at RCMP HQ in Regina. It could be argued that the DEOC at any given time would have had the most up to date and 'real time' information related to the events that were unfolding on the JSCN and in Weldon. As an extension of the OCC, the MOSS member(s) that were embedded in the OCC could have easily acted as that conduit should they have been invited to briefings that were being held daily.

Technological issues and lack of interoperability between the DEOC and OCC were covered earlier in 'DEOC Functionality'.

Although less common, there were reports of information being received at individual detachments, as opposed to coming through the OCC. For clarity, when the public calls an RCMP Detachment, they can call the 'admin' line or the 'complaint' line. If there is no one physically inside the detachment to take the call, the usual process is that a message can be left on the 'admin' line or, if the 'complaint' line was called, the caller will be re-directed to the OCC. All calls in to the OCC are recorded and OCC operators are trained to gather appropriate information. Should a call have been received by the administrative staff at any of the detachments, the call is not recorded and there is no guarantee that the information received would have been forwarded on appropriately. As a remedy to this issue, phone lines in the immediate area of a major event can automatically be forwarded to the OCC to ensure recording capabilities and consistency of forwarding the information. It should be noted; however, that utilizing this remedy of automatic call forwarding could result in a number of non-pertinent and/or administrative calls being forwarded to OCC thereby further increasing their call volume.

Given the sheer number of calls that OCC Operators were dealing with in relation to the JSCN and Weldon it was inevitable that some callers had to be put 'on hold' or would have received an automated message, at times. The current 'call queueing' software that the OCC uses does not differentiate between 911 calls and less urgent calls that are in the queue, thus preventing OCC Operators from prioritizing the 911 calls. This problem will be solved with the installation of a new system ***(Next Generation 911)*** that is to take place later this calendar year.

Radio Coverage Issues:

In order for police to perform their duties effectively and safely, they must be able to communicate both with each other and with the OCC. OCC and members who regularly work in Melfort are all aware that historically there are 'no coverage' areas within the Melfort detachment area, mainly for portable radios. This communication gap has been a persistent problem and was evident during the events that transpired on September 4th. During the course of this review it was found that a significant number of members were either unable to communicate appropriately through their portable radios, or had to utilize an alternative form of communication to update their status or to relay information. As a result, information would be pieced together between radio and cell phone calls in to the OCC, which is not an ideal situation. The inability of members to readily communicate with one another is a threat to both police and public safety. New radio sites are an option for better coverage; however, they are very expensive to procure and to provide coverage in all locations, would cost several millions of dollars.

Recommendation 6.3 - Continue to work with the Province of Saskatchewan and the JSCN Band Council to address radio communication shortcomings.

Recommendation from MacNeil Report (Moncton 2014):
7.2 It is recommended that Codiac detachment radio coverage be examined outside of Moncton center to rectify areas that have gaps in coverage.

Although the solution to this problem goes beyond the scope of this review, recognizing it and identifying steps that can be taken to help mitigate the problem in the short term, should be clear. To understand the process, there first needs to be an understanding of the various agencies/units involved, and their roles.

Informatics:

Generally, when members experience some type of 'tech' issue, their first attempt at problem solving occurs 'in house' followed by Informatics. The Informatics unit is well known amongst the RCMP. Members for the most part, are aware that when they are confronted with some type to 'tech' issue, this is the unit to contact.

Informatics in 'F' Division is made up of three units designed to assist with technical issues that RCMP employees may experience.

Information Technology consists of seven units across Saskatchewan responsible for the support maintenance of all ***voice and data technology*** within the division. Their role is to provide leadership, technical solutions, installation, support and on-going

maintenance for all computer, voice and data, mobile data, and mission critical systems in Saskatchewan. ***Radio inoperability issues would fall to this unit.***

Information Management is responsible for all corporate information that must be managed within the existing Information Management systems that reflect the day to day business of our operations. This information must also be accessible and retrievable at all times to respond to Access and Privacy requests.

Operational Support looks after IT procurement (acquisition), and application services. Consultants are available to work with units or detachments on projects such as obtaining new computers or software.

When dealing with the issues of radio inoperability, the solution is not as simple as having the Informatics unit simply travel to the area where coverage is weak and set up a radio tower. There are Saskatchewan Government agencies that oversee the entirety of emergency services management that will be explained below.

Provincial Public Safety Telecommunications Network (PPSTN)

The ***PPSTN*** is the agency that manages the radio network through a partnership between SaskPower, the ***Saskatchewan Public Safety Agency (SPSA)***, and the RCMP. The ***SPSA*** is the government agency responsible for provincial emergency management, fire safety and wildfire management in Saskatchewan and ***manages Saskatchewan's 911 emergency dispatching services***.

PPSTN provides the RCMP with interoperable radio communications that allows them to communicate with other agencies (EMS, Fire, etc) during times of emergency.

There are PPSTN emergency response professionals ready to respond day and night to problems that may affect one or several of the more than 250 radio towers located in the province. They are available 24/7 to respond to a crisis at a moment's notice.

PPSTN also have access to ***Mobile Communications Towers (MCT)*** which are equipment trailers with a 100-foot telescoping tower that can bolster radio coverage for specific incident responses.

Specific to the JSCN/Weldon event, when radio coverage was deemed to be an issue, the OCC was notified and, in turn an Informatics manager had the authority to approve the use of a MCT. An employee of SPSA was notified and drove the tower to the site where Informatics was responsible for setting up of all the technology. ***A portable radio***

tower was set up in Melfort by September 5th which alleviated some of the radio coverage issues.

[redacted]

Radio Coverage – No MCT

Radio Coverage – With MCT

Digital Vehicular Repeater System (DVRS):

As was described earlier in the review of the tactics and response to the initial call, another way to mitigate areas of inadequate portable reception, can be by using ***DVRS***. DVRS is an 'in vehicle repeater' that when used properly ***can extend the range of portable radios*** when normal PPSTN portable radio coverage is unreliable.

Essentially, DVRS provides anyone with a line of sight to their police vehicle to gain better reception on their portable. [redacted].

There are clear instructions on the ***'F' Division Infoweb – Informatics*** on how to use DVRS along with an instructional video that can be emailed to members, if requested.

DVRS have only been deployed to [redacted] of police vehicles in the division due to prohibitive costs. Further, repeater system has not been well received/used by members as it is viewed as only useful in a limited number of situations and requires tactile manipulations of the radio that, in a high stress situation, are not realistic.

BeOn App:

In response to Health and Safety complaints filed by members who were negatively impacted due to a lack of portable coverage during certain incidents, the 'F' Division Senior Management Team (SMT) ran a pilot project from September of 2021 to January of 2022 to investigate alternative communication methods. As mentioned earlier, new radio sites are expensive and would take time to procure and DVRS, although available, has limitations and is not widely accepted or used my members.

As a result, SMT selected a detachment in each district to run a pilot project using the BeOn application. BeOn is an ***application installed on a cellular device*** that provides Push to Talk (PTT) radio communications similar to a portable radio by using commercial cellular networks to connect cell phones to the PPSTN. This Push-To-Talk-over-Cellular (PTToC) technology ***provides users the ability to communicate on the PPSTN when regular radio coverage is not available***.

Among some of the positive aspects of BeOn were that members liked the additional coverage [redacted] and that detachment commanders were able to monitor calls from home or inside the office. Provided there is adequate cellular coverage BeON will work over WiFi network, if the phone is connected.

Advantages

- Provides radio coverage where PPSTN is unavailable
- Member are already in possession of cell phones

Disadvantages

- Currently does not have the ability to Request-To-Talk (RTT)
- [redacted]

- App is free to download and license costs are approx. $260/device (portable cost approx. $400 ea.
- [redacted]
- BeOn has an Emergency RTT function built in

[redacted]

- Requires an internet connection to the PPSTN core that requires further security measures (firewalls)
- Possible for BeOn to miss calls or be unable to place calls during high usage time on cellular networks
- Members will need to be trained
- Should be used as a backup system
- There is a chance that changes made to smart phone Operating Systems by SSC could impact BeOn functionality
- Mapping function is unreliable.

The obvious considerations of cost, time, and resourcing to install this type of application have yet to be determined; however, the recognition by management of the areas of poor radio coverage illustrate the efforts taken to improve the situation.

Member Status Updates:

There were some ***100-130 cars logged in with OCC*** at any given time during the event on the JSCN and in Weldon. Due to resourcing shortages in the OCC; however, dispatchers were unable to conduct regular status checks on members. On scene commanders were doing their own focused status checks; however, it was unrealistic for the OCC to know the status of every member at any given time. There were options available to provide a more accurate account of members' status and an overall ***Common Operating Picture (COP)*** that will be explored below.

SAMM/CIIDS System:

Every member that was logged in to their Mobile Work Station (MWS) had the ability via the Status and Messaging Module (SAMM) function and in conjunction with the Computer Integrated Information and Dispatch System (CIIDS) system, to allow for constant communication between themselves and the OCC.

Members could have alleviated some of this stress on the OCC by updating their status on their own via their MWS; however, ***as mentioned earlier in the review of the Command Structure, not all members were utilizing this function of their MWS.***

Radio contact was maintained as best as it could have been to help with establishing a COP; however, if members were in their police vehicles, OCC generally had a clearer picture of where they were at any given time.

Despite the efforts of those that were updating status via their MWS and CIIDS, the mapping software in the OCC was not working properly at the time of the event and as some areas of the map showed up as an 'empty box' on the computer screen. Google Maps was used to supplement the CIIDS mapping deficiencies.

Recommendation 6.4 - Update CIIDS Software to include a mapping system and the ability to share vital information as perimeters and location data.

Android Team Awareness Kit (ATAK) System:

ATAK, as discussed, is an application that can be useful in assisting with generating a COP for deployed resources. ERT was using ATAK at the time of the JSCN event; however, the system was not working in the OCC during that time, preventing the OCC from being able to track ERT movements. As previously covered, steps are being taken in 'F' Division for a divisional implementation of ATAK that should remedy these issues.

Radio Communication - Interoperability:

The JSCN/Weldon event elicited a response not only from the RCMP in 'F' Division, but other RCMP Divisions, municipal police forces, and agencies. In order for immediate radio communication to occur between agencies (interoperability), there are many factors at play. It is not as simple a pushing a button and having the ability to speak with a member from a different police force, or even another province.

Through the OCC, there are a number of interoperability options available ***(F Div Ops Manual 46.100.5.8)***.

Saskatchewan/Alberta RCMP Communication:

The ***Network First Gateway*** will allow any 'F' Division radio on the PPSTN system to talk to any 'K' Division radio on the Alberta First Responders Radio Communication System (AFRRCS) system, simply by requesting a patch through OCC. Further, there are three talk groups: [redacted] that are being programmed into all compatible radios, at detachments bordering Alberta.

RCMP/Municipal Agency Communication:

The OCC has the capacity to request a radio patch through to the other agencies. This interoperability is programmed into police radios and can be used to communicate with any other agency on the PPSTN radio network including PA Police Service, Weyburn

Police Service, and all Fire and EMS in the Province. To communicate with non-PPSTN agencies such as Regina, Saskatoon and Estevan Police services, OCC can create a patch to those external agencies as well.

[redacted]

[redacted]

Radio Communication – 10-Codes vs. Plain Language:

Historically, RCMP members have been taught to use 10-codes mainly because they are short and to the point. The drawback to using 10-codes however, is that their numbering is not standardized and not every police force uses the same codes which is problematic when multiple agencies are responding to the same incident. As a result, 'plain language' in certain situations should has been accepted, rather than communication over the radio in code.

According to policy, when operationally practical, RCMP members and OCC operators are to use 10-codes for radio communications. However, for multi-agency and/or multi-discipline communications, plain language should be used in place of 10-codes. ***(RCMP Policy – Informatics Manual Ch. II.2.11)***

Part of the problem with using plain language is the possibility of transmitting private information over the airwaves can fall into the wrong hands. As the public routinely monitor police calls on scanners, some plain language has the potential of disclosing sensitive information about police or victims. Proper radio communication in critical situations will always attempt to strike a balance between the type of information that can be broadcast in plain language, or not.

From an Operational Communications perspective, radio communication as a whole was deemed appropriate throughout the JSCN event. There were very few instances of unnecessary radio chatter nor were there instances of confusion when using 10-codes were being used. For the most part, plain language was the primary mode of communication.

Recommendation from Moncton: 7.13 It is recommended the RCMP create policy that allows for the use of plain language as an alternative to 10-codes in urgent situations.

Supervision:

OCC supervisors were deemed to have done an adequate job of maintaining communication with their operators. Further, having a full time MOSS member embedded in the OCC and attached to each team was viewed as an essential component for a situation such that unfolded at the JSCN and Weldon. The MOSS Unit was discussed previously in 'Command Structure'.

Mass Casualty/Victim Response

The events of September 4th will have life long effects on the communities of JSCN and Weldon. There is no disputing this. No amount of support will erase the memory of what occurred during that time. The assistance and supports provided to victims following an experience such as this can; however, play an important role in helping cope with the impact the event has caused. This section will document the role that the RCMP played in the response to the victims, their families, and the community within the early hours and during the aftermath of this tragedy.

Initial RCMP Response

Sergeant Ashley St. Germaine (Sergeant St. Germaine) of the Prince Albert General Investigations Section (GIS) was notified by her supervisor on the morning of September 4th that MCU out of Saskatoon was requesting the assistance of her unit on the JSCN as a result of what was unfolding. By this time, MCU had taken control of the criminal investigation and were at the early stages of accessing and processing various scenes and concentrating efforts on locating and apprehending the suspect(s).

Effective Practice:
Assigning the functional role of family liaison to deceased victims' next of kin should be done as early as possible by the Team Commander.

Prince Albert GIS is a small unit of 6 members; however, they were operating with 1 vacant position at the time of the events of JSCN and Weldon. Sergeant St. Germaine immediately secured 4 resources (herself and 3 others) to travel to Melfort to meet with MCU. ***At this point in time there was no specific role that was assigned*** to Sergeant St. Germaine and her team as the number of reported victims (both injured and deceased) was increasing along with the number of scenes and everyone was still trying to ascertain the scope of what they were dealing with.

Upon arrival in Melfort, Sergeant St. Germaine and her team met with MCU and obtained names and contact numbers for the Crime Scene Manager as well as a Victim Services Unit worker. Her team was tasked with travelling to JSCN in order to start making contact and to initiate communication with victim families.

It is common practice in homicide investigations, for MCU to dedicate a single member to take on the role of the 'Family Liaison'. Due to the number of victims, however, Sergeant St. Germaine and her entire GIS team were tasked to begin organizing and completing Next of Kin (NOK) notifications for the deceased victims.

Sergeant St. Germaine recognized the importance of her teams' role during this event. She immediately recognized that ***her team's role was to provide accurate and timely***

investigative updates to those families and people, and to provide a link to RCMP Services (like Victim Services) if required. Although there was no official term for what Sergeant St. Germaine was tasked with, her role evolved into that of '***Victim Family Liaison Manager***'.

Upon arrival at the JSCN, Sergeant St. Germaine met with the MCU crime scene manager and a Chief at JSCN Band Office to begin the process of obtaining names of those that were deceased. The Chief provided her with an initial list of victims who were both deceased, and injured. This list was the starting point for what would become a complete list of deceased victims, surviving victims, and points of contact.

After obtaining names, Sergeant St. Germaine and her team set out to the various scenes in order to identify victim family members and begin the process of communicating with them. Upon arrival at the various scenes, many of the victims' family members were already present, therefore identifying the various family contacts was done quickly, along with the NOK notifications. The priority was to make initial contact with the various deceased's' families; however, during this communication many other names of those that were injured and were witnesses were being relayed.

Sergeant St. Germaine distributed names of the deceased's families and surviving victims amongst her staff and assigned them as ***primary points of contact for the RCMP***. Consideration was given to those members that were dealing with the suspect family as well as the suspect's brother's family as she was aware that those interactions would require more dedicated time. As such, fewer additional contacts were assigned to those members.

Effective Practice:
The ratio of number of points of contact or family members assigned per Family Liaison should be kept as low as possible and consideration given to those roles that will require more time and sensitivity.

Communication with the Mass Casualty Response Team:

By the end of day on September 4th, following the completion of all NOK's for the deceased victims, Sergeant St. Germaine began receiving assistance for the next phases of victim support. She reached out the 'Mass Casualty Response Unit' (explained further below) to obtain any information that she could, from them, as to further steps that she and her team could take. After conversation, many of the immediate concerns that were raised had seemingly already been addressed; however, their input was valuable. Throughout the following week while the Mass Casualty Response Team was on site and

offering assistance, Sergeant St. Germaine considered any of the advice that was offered with the lens of the Indigenous needs first and foremost.

Barriers Experienced:

Tracking Victims:

Some difficulties were experienced when making a determination as to whom the injured victims were, whether they had been transported to hospital and if so, what facility. Due to the sheer number of autopsies being performed, once they were completed and the victims were transported to another location, it was initially unclear where they were being taken. This information was eventually collected through from the Saskatchewan Health Authority (SHA) and was provided regularly, with updates on patient status, and whether they had been transferred or discharged. This information ended up being vital to locate, identify, and support the victims and their families.

Timing of Media Releases:

The suspect's brother's body was discovered on September 5th and identification confirmed a short time later. Upon being made aware of the positive ID, two members of the Family Liaison Team were tasked to conduct NOK notifications on the victim's wife and mother, on the JSCN. Liaison Team members attended a residence to find that the family members were not present and had travelled to Melfort. While members were attempting to make in person contact with the family, a media availability time had been booked in order to release the information of the death and news surrounding that. The time the media conference had been arranged for did not provide enough time for the Family Liaison Team to travel to Melfort to find the family, notify them, and in turn, advise the JSCN Band membership. The news conference happened almost simultaneously to these notifications. The Family Liaison Team would have appreciated the opportunity to notify the reminder of the victim families prior to the media conference but were not afforded the time due to the tight constraints they were confronted with. As such, many of the victim families found out about the suspect's brother's death through the media, in stead of in person from an RCMP member.

Recommendation 7.1 - Promote direct contact between the family liaison and the media liaison (or via the MCU CT) in order they consider the impact of scheduled media events on the various investigating units, including the Family Liaison Teams.

Communication:

After being tasked by MCU and understanding the importance of being able to relay timely and accurate information to the various families, the TC, PI and Sergeant St. Germaine made the collaborative decision to work alongside each other in Prince Albert. This move offered easy and direct communication between them and her team. This was a seamless transition as Sergeant St. Germaine and her team had a pre-established working relationship with MCU.

Effective Practice:
Family Liaison Team Managers/Supervisors should co-locate with the Command Triangle or Investigative Team to support communication.

As the single point of contact, Sergeant St. Germaine was able to frequently exchange information with Victim Services Resources and the JSCN Band Office and their Emergency Operations Centre (EOC). Further, Constable Christian Stroet (Constable Stroet) was assigned to liaise with the JSCN Band Office EOC as another liaison between Sergeant St. Germaine's GIS team, the MCU CT, and the JSCN Band. This contributed to a better understanding of the various support resources being offered to families by both parties (VSU and the JSCN Band). VSU's role will be explained in more detail, later in this section.

The identified role of the Family Liaison within the EOC proved to be an important link between the JSCN Band and the RCMP. The three Chiefs from the respective Nations, a representative from the Prince Albert Grand Council (PAGC), and RCMP Indigenous Policing (explained below) were also represented in the EOC. This environment was utilized to communicate issues back and forth and to identify community needs/perceptions in a timely fashion. It was noted that some JSCN community members were uncomfortable speaking directly with the police during the search for the suspect and some information was passed through the Chiefs, which had implications for timeliness and accuracy of information but overall, communication flowed both ways, efficiently.

Another important function of having a RCMP member embedded in the EOC was that of managing community expectations of police abilities and limitations. An example of this was explaining the processes involved in obtaining the services of the RCMP helicopter and how those services cannot be garnered in mere minutes of a tip coming in or during some of the apprehension phases. This communication was crucial in maintaining healthy and functioning relationships in that environment.

The type of communication with the various victim families was found to vary, depending on the type of information that was being relayed. When there were updates to the investigation or any real time information to be forwarded, families for the most part preferred this come from an RCMP member. Aside from those updates, however, families wanted to hear from the Band or the Chief(s). Additionally, after the initial contacts and investigative updates were forwarded, most families preferred text messaging as opposed to 'in person' visits or even phone calls. There were strong feelings from some liaison team members that it should be up to the individual families as to how often they are contacted and by what means. Expectations can vary from family to family as to what their expectation for support and receiving information is. For example, liaison team members experienced the family of a victim preferring to get their support and information from non police sources within their community at one point.

Whatever the level of support and communication that is preferred, the Family Liaison Team's sights were always on showing respect to the families and victims. Evidence of this is when liaisons notified family members and survivors of upcoming RCMP media releases, to ensure they were given advanced knowledge and not caught unaware.

The Family Liaison role became a benefit to the overall investigation as well. Due to the prolonged contact that members had with the victims' families, the Liaisons would regularly receive information that could either be actioned or passed on to the investigative team in a timely manner. An example of this was when a member of the liaison team learned information that some community members were considering launching a 'manhunt' for the suspect(s). Liaison Team members were able to dissuade this group and mitigate the risks that spontaneous initiatives such as these could have on public safety and investigative efforts by police.

The amount of work required to keep the families informed as much info as possible without compromising the investigation became more than expected or anticipated. Indigenous Policing Services (explained further below) became involved and were tasked with forwarding information to some of the impacted families as well which alleviated some of the workload.

Because of the focus that was placed on the JSCN throughout, the fact that there was a victim from the community of Weldon as well, could have been lost. This was not the case, however, due in large part to the role of the Family Liaison.

Areas of Effectiveness:

Despite there being no specific RCMP operating procedures or guide for the role that became the Family Liaison Team, Sergeant St. Germaine and her team established their role quickly and sought assistance from various resources when necessary. They were able to establish themselves as the main points of contact for representatives from families of deceased victims and with surviving victims directly.

Since the JSCN mass casualty event, Sergeant St. Germaine has attended the *Canadian Association of Chiefs of Police* workshop related to piloting a Canadian ***Victim Response Framework for Mass Casualty Events***. A meeting has been arranged in early 2023 to have formal discussions with 'F' Division CROPS (with support from the District Management Team and MCU) as to the creation of a more formal framework for addressing some concerns raised in the response to the JSCN/Weldon mass casualty event.

Recommendation 7.2 - Consider seeking out additional training for select members and/or supervisors in the area of mass casualty events. Training should include recommended deployment and reporting structures, documentation processes, and the function of Family Liaisons during events such as these.

Indigenous Policing Services' Role

Prior to a review of the role that Indigenous Policing assumed during the JSCN event, it is relevant to document the service that they strive to provide and the goals they set out to accomplish.

About Indigenous Policing Services (IPS):

IPS in 'F' Division strives to ensure the delivery of professional and culturally relevant police services to all of Saskatchewan Indigenous people within RCMP jurisdiction. The IPS Unit consists of seven 7 members ranging from an Inspector to Corporal(s). ***Other Divisional IPS members were deployed specifically in response the JSCN incident, namely: 2 members of 'K' Division IPS and 1 member from 'J' Division.***

IPS Mission:

The IPS mission is to support employees in providing professional, proactive, and culturally appropriate policing services to Indigenous people and communities in Saskatchewan. With guidance, education and collaboration, IPS assists in the

advancement of Reconciliation and strives to improve overall relations between Indigenous people and the RCMP.

IPS Mandate:

'F' Division Indigenous Policing works with all levels of government, Indigenous leadership and key partners to improve relationships between the community and the RCMP, to ensure culturally appropriate policing.

IPS out of Prince Albert took on the role of liaison between the RCMP and the Band Council for the JSCN event. IPS became embedded in the EOC very early on. IPS members identified that their being present 'on the ground' in JSCN on the first day was essential in providing a base for support, especially at a time when fear was rampant with the suspect being at large. IPS's presence fostered regular, in person communication with the 3 Chiefs and Grand Council where updates could be given and information from the Band could be relayed back to the investigative teams.

Other agencies that had a place at the table in the EOC were the Federation of Sovereign Indigenous Nations (FSIN), Indigenous Services Canada (ISC), and representatives from Public Health and Mental Health. The managers of the assisting agencies were there to discuss the event and safety concerns. IPS's role in this setting was that of a liaison between the RCMP and those agencies and representative at the table during briefings, for the RCMP. Attendance at these briefings and visibility within the EOC was important in building and maintaining the relationship between the RCMP and the Band. It opened a line for honest communication and through this, IPS members were able to build trust and rapport while at the same time providing and disseminating timely information through the appropriate RCMP channels.[190] IPS members worked directly with the MCU Command Triangle in order that they had investigative information that could be relayed back to the families.

IPS's role was noted to be a critical part of the relationship based connection between the JSCN and the RCMP. The recognition by 'F' Division management for enlisting IPS resources from other divisions cannot be understated. The nature of their role became that of an informal liaison, which allowed them to build strong community relationships. This 'informal' relationship was noted in interviews with some community members where they commented on how 'authority of the RCMP' was not at the forefront of communications with the community during the incident, but rather a more empathic tone was conveyed. The IPS component became important as concerns from the JSCN community began to be forwarded to IPS members surrounding the anticipation of RCMP

resources and support becoming non-existent, after the event had concluded. IPS was able to relay these concerns to the Family Liaison Teams and allowing the Liaison Teams to convey the messages that they would remain available and engaged even after other members had left the JSCN.

As mentioned previously, there is a Melfort RCMP member that works closely with the JSCN community and is highly spoken of. This positive pre-existing relationship helped greatly with IPS's ability to assume their role in the EOC.

This notion was evidenced in a number of interviews from the Community members that were conducted during the later portions of the review where it was pointed out that the presence of RCMP members at the EOC briefings was both valued and appreciated.

Effective Practice:
Requesting out of division IPS resources to increase needed capacity in this area, and embedding a culturally appropriate representative within the EOC in order to be the direct line of communication between the Band and RCMP.

IPS members were said to have been regularly engaged in the community, being supplemented further by the designated member from Melfort. That being said, according to a number of community members, there is room for improvement in the relationship between the Melfort RCMP and the JSCN. ***This topic was covered earlier in review of the tactics and response to the initial call.***

Throughout the JSCN/Weldon event, IPS played an invaluable role in establishing and maintaining communication and information sharing between investigators and the JSCN. RCMP commitment and support to IPS is important to ensuring future incident response and service delivery are as safe and effective as possible.

Cultural Sensitivity:

Given the rapidly evolving situation that members were responding to on the morning of September 4th, being culturally aware of the overall impact of this tragedy could have been overlooked, creating boundaries and hindering community trust toward the police. Quite the opposite occurred. There were a number of instances highlighting the efforts made by the responding members that showed empathy and an understanding of the cultural needs of the community.

Post Mortem Ceremonies:

Members that were tasked with attending the various homicide scenes were confronted with balancing their duties as police officers by securing the respective scenes to ensure continuity, with the needs of the community and supporting cultural ceremonies be conducted in relation to the various deceased.

The importance of these post mortem ceremonies became clear and were recognized and respected by RCMP members. As was mentioned earlier, when members arrived at various scenes, family members were gathered near the body in a number of instances. This was not anticipated by some of those on the liaison teams; however, the importance of supporting cultural practices surrounding the deceased was recognized immediately. It was critical to families that they be allowed to perform cultural ceremonies that did not interfere with the scene/evidence preservation prior to transportation of the body. Families were appreciative of being allowed to perform the important cultural ceremonies including prayer circles and smudging. In one instance, Liaison Team members worked with the Coroner's Office to halt the transport of a deceased victim until such time that the family could view the body and perform a cultural ceremony.

Recommendation 7.3 – Drawing on experience from this event, consider generating some type of 'Legacy Document' to be disseminated divisionally, outlining various cultural considerations that are necessary to provide appropriate support for victim families.

The JSCN Band took the lead on contracting out the cleaning of the various scenes and the remediation process that that was required prior to releasing the homes back to their owners. An Emergency Protection Officer (EPO) for the Saskatchewan Emergency and Protective Services for First Nations was in charge of coordinating the process and was in tune with the cultural practices that were required, such as smudging the home prior to them being cleaned and to burn anything with blood. This practice was not recommended due to the extent of blood contamination therefore scraping items with blood and burning the scrapings or removing items from the home for smudging was an agreed upon alternative.

A contractor was hired to repair damages caused by the suspect as many doors were damaged in during the attacks. During EOC meetings, the EPO recommended that the victims families be updated on the state of their homes so they weren't traumatized when the arrived at home and saw walls/carpet removed/repaired.

On a broader scale, over the course of the initial days and weeks to follow, various RCMP members were involved with cultural events on the JSCN that included the smudging of houses with community Elders prior to victims/families returning to them, attending funerals, pipe ceremonies, and sweats. In one instance, a RCMP member brought rocks into the sweat, an act that was viewed favorably amongst Band leadership. IPS organized a sweat with the various RCMP Commanders, Saskatchewan Environment Resource Management (SERM) Officers, members from MCU, and the Family Liaison Team.

IPS took a proactive role in both planning and participating in regular cultural activities throughout the duration of the event. IPS representatives attended morning pipe ceremonies, allowing for crucial face to face contact with Band leadership and present the platform for question and answer sessions from community members, on a daily basis. The steps that were taken by the Family Liaison Team and IPS to recognize the significance of traditional Indigenous ceremonies, while maintaining the integrity of the investigation, was appreciated.

Victim Services Unit (VSU) Role:

Victim Services Units (VSU) offer assistance that varies from more immediate services, such as crisis support to more long-term assistance such as informing victims about court processes. In addition to these services, other commonly provided types of assistance include giving referrals, providing information on the criminal justice system, informing victims about victim impact statements, and accompanying victims to court.

Victim's services offer support, assistance, information, and referrals in a compassionate manner that respects the dignity and privacy of those dealing with the impact of victimization.

VSU's in Saskatchewan are funded by the Saskatchewan Ministry of Justice, and are governed by an RCMP Board. Each RCMP based VSU program is administered by a local non profit board of directors. These boards have representation from community stakeholders and the RCMP. RCMP detachments provide office space in the detachment including phone, computer, and office supplies. Programs are staffed by community volunteer support workers and managed by civilian employees. Individual VSU's are their own entity, however, and make decisions based on their own assessments. RCMP members can provide relevant information to the VSU, but the decision to provide assistance lies solely with the unit itself.

The ***Northeast Regional Victim Services (NERVS) Unit*** specifically, was the group that responded to the JSCN. NERVS is comprised of one full-time coordinator, one full-time

assistant coordinator, two part-time assistant coordinators, a part-time administrative assistant, and 18 volunteers. The NERVS Region encompasses a very large geographic area including the JSCN and Weldon.

The NERVS Unit has paid staff that work on an on-call rotation; however, they do not receive any monetary incentive in return. Staff can bank on-call time at a rate of 1 hour of banked time for every 24 hours on-call. They receive hour for hour banked time for time worked during a call out. ***This funding arrangement has been the main difficulty with both staffing and staff retention***.

NERVS Unit referrals from the RCMP are typically communicated in a phone call from an RCMP member requesting victim services. When the unit receives a referral, it is first offered to a volunteer. If no volunteer is available, one of the paid staff members works directly on the referral. The NERVS Unit was noted as having a good relationship with the Melfort RCMP as the detachment was viewed as being very 'pro-VSU' and the NERVS Unit itself, felt that support.

Note: The NERVS Unit previously responded to the Humboldt Broncos Bus Mass Casualty (2018), and the La Loche school shooting (2016). Based on these past events, this team was well versed in mass casualty response.

NERVS Unit Response:

On September 4th, the on-call coordinator was first made aware of what had occurred on the JSCN when she was contacted by the Melfort hospital advising of the arrival of a number of victims from the JSCN and the hospital. The Melfort Hospital does not have medical social workers and was requesting NERVS Unit attendance to fill that support gap. At this point in time the NERVS Unit had not yet been contacted by the RCMP.

The attending coordinator began organizing volunteers via a group chat requesting attendance at the hospital in order to begin meeting with any victims that were in need of services. ***At this point in time, VSU efforts were focused on the victims at the Melfort Hospital and making a determination of who required support at that location.*** Contact was made with medical social workers at other locations (Saskatoon and Prince Albert) when patients were transferred out of Melfort, in order to continue that support on the receiving end.

Communication with both the JSCN Band Leadership and Weldon community leaders began on the first day. During these contacts a list of supports and resources that were available via the NERVS Unit were discussed and ultimately accepted. Throughout the

initial day, those members of the JSCN that lived in homes that were now considered crime scenes, would need alternate accommodations and some others simply did not want to remain in the community. The NERVS Unit worked with the JSCN, FSIN, Prince Albert Grand Council (PAGC), and Red Cross in efforts to secure hotel costs for victim families.

The NERVS Unit was contacted by Staff Sergeant Simons from the Melfort RCMP approximately 2 hours after being alerted by hospital staff. By this time, the NERVS Unit volunteers were already at the Melfort Hospital providing assistance and ***their role did not change following their conversation with Staff Sergeant Simons.*** Although the NERVS Unit coordinator did not have all the information regarding the status of the investigation at his point in time, the determination was made that ***NERVS Unit workers would not be travelling to the JSCN due mainly to safety concerns.***

On September 5th, the NERVS Unit met in person with Sergeant St. Germaine. At this time there was very little information available as far as those victims that would require support. The list of victims that was forwarded was incomplete and still being compiled. While it was clear to the NERVS Unit workers that those on the list were deceased, other details were still not known and/or provided to Victim Services. Further, some victim services referrals were missing pertinent information including accurate phone numbers. It was understood by the NERVS Unit that the situation was still evolving and the information may be forthcoming; however, not having the ability (as will be set out below) to assist the RCMP in compiling the pertinent information was perhaps the biggest barrier to providing assistance.

Eventually Sergeant St. Germaine generated a spreadsheet with victim and family contact information in order to track both contact with the various families and the assigned members. In conjunction with the Mass Casualty Response Team (as set out below) this document was evolved, was updated, and continues to be an invaluable resource for those tasked as part of the victim support team.

Effective Practice:
The digital tracking and documentation of victims deceased and injured, their next of kin or family contact information, and relationship is critical. A digitally formatted document for ease of updating and sharing between investigators, family liaisons, and Victim Services is recommended.

VSU in Saskatchewan do not have access to the PROS database which causes a massive information gap between the RCMP and various VSU's. ***The inability to conduct***

database queries for basic details such as contact information is paralyzing for a unit that places such a value on being able to make timely contact with victims. The NERVS Unit believed that their ability to make these queries would have benefitted both the RCMP because it would have significantly reduced their workload, as well as their local VSU as they would have had the most up to date and timely information available to do their job.

It appears that restricting access to PROS is not only a Division-wide policy in Saskatchewan, but rather extends nation-wide. Since the implementation of PROS as the preferred Records Management System (RMS) for the RCMP, access was withdrawn from Victim Service units. Compared to previous RMS used by the RCMP (Police Information Retrieval System - PIRS), PROS contains several detailed fields of information as well as access to numerous reports, some of which contain sensitive information. As such, access to PROS became restricted, only granting to employees of the RCMP. For obvious reasons this was viewed as an impediment by VSU employees.

Eventually the NERVS Unit received names identified by the Family Liaison Team for follow up. NERVS workers travelled to the JSCN to meet in person with victims; however, during this time there were not many people remaining on the JSCN, as the suspect was still at large and many had vacated their homes. As such, home visits were paused. NERVS Unit provided the RCMP Liaison Teams with a list of available resources that the members could forward to victims and injured during this time that the NERVS Unit was not allowed on the JSCN. Eventually, a more fulsome list of names was provided by the RCMP and NERVS Unit workers began making phone contact with victims, on the evening of September 5th.

This contact continued and, by the end of day on September 6th the NERVS Unit had received a list of witnesses (anyone who directly witnessed the incident or was exposed to trauma) from the RCMP Liaison Team. This witness list was divided between staff and their time was spent calling these clients on September 7th and 8th.

In addition to client contact, the NERVS Unit was working with the JSCN Crisis Team to arrange for counselling services from victim families and obtain information on funeral costs. ***By this point, the NERVS Unit was becoming over tasked. The small unit had been working long hours in emotionally draining situations.*** Witness files that were opened were distributed amongst the NERVS Unit, Prince Albert VSU, and North Saskatchewan VSU. If those that required support were re-located to other places such as Saskatoon, those VSU's were contacted in order to continue support.

The NERVS Unit recognized the importance of providing support for the Weldon community members and had concerns that the multiple agencies that were offering support to the JSCN were unaware of the same need in Weldon. NERVS Unit workers attended Weldon for a community debriefing in a support role for the friends and family of the deceased on September 8th. They advocated for the Weldon victims home to be cleaned and ultimately, federal government provided the funding. A relief team attended Weldon again on October 11th to 14th.

Once the suspect was arrested on September 7th, VSU resumed home visits on JSCN, beginning on September 15th. These visits were guided by clients' wishes. During the week of September 19th, a relief team arrived and assisted with proactive door knocks in the community (JSCN and Weldon) to distribute a resource package with information about victim compensation. In the JSCN specifically, a local community member was assigned to accompany the relief team with door to door contacts in order to provide these resources. Shortly after starting, the community member expressed their belief that all supports and services should come from the JSCN and not an external body (like the Ministry of Justice). Further, there was some ambiguity in the information that was being presented to victims regarding compensation that some community members thought may confuse victims. As such, on September 23rd the door knocks were stopped and VSU have not returned to the JSCN. The JSCN leadership was unaware of the concerns and eventually reached out to the NERVS Unit to talk about the misunderstanding. The relationship between the NERVS Unit and the JSCN Band Leadership remained intact following this and the NERVS Unit continues to work with victim on the JSCN when they are requested.

Throughout the incident, the NERVS Unit was in communication with the Ministry of Justice. Specifically, as the days went on and the number of referrals was increasing, as mentioned above, the NERVS Unit was becoming overtasked and burned out. In addition to providing support to those for which they had generated files, NERVS workers attended funerals, conducted home visits, and provided support to staff and students at school, among other duties. The NERVS coordinator contacted the Ministry of Justice to arrange for a relief team of VSU workers to support their teams' efforts. The Ministry of Justice advised the relief team would be created, however, left all the coordination and logistics to the NERVS Team, which just added to their workload. The Ministry of Justice might have been the better point of contact with the JSCN leadership to provide clarity regarding the role of the relief team to mitigate conflict. Further, that department might have led the

development of the Relief Teams. Putting the coordination and organization on the core victim services team added considerably to their workload and stress.

Recommendation 7.4 – Based off experience from this event, National consideration should be made for the development of Mass Casualty or Mass Fatality 'Victim Support kits'. This kit could include guiding documents, pre-printed victim support pamphlets (in multiple languages), and program referral links. These kits could be stored electronically and/or pre-assembled at a District or Divisional level.

At the time of the incident, some RCMP members interviewed described their understanding of the functional roles of RCMP Victim Services as limited. Some were not aware if there was an electronic database or website of Victim Services they could offer to families. In advance of this incident, some members had no knowledge of the support that could be provided by Victim Services and all but associated VSU with options for providing/connecting with counseling. Since this event, members have learned more about what VSU can offer.

Despite the organizational structure of the NERVS Unit as described above and the number of resources that are ideally assigned, the reality is that there were approximately 5 NERVS Unit members that were involved in the JSCN response. When dealing with deceased victim's families, injured victims, witnesses, and community members, the file count is well over 100. This became unmanageable and unit members are not well. The NERVS Team has yet to receive any type of incident debrief and have no compensation for any type of counselling services, should they require. This incident has stretched their unit capacities past their limit.

Recommendation 7.5 - Employees of Victim Services should receive the same access to Critical Incident Stress Debriefing and Wellness programs in recognition of their ongoing, primary functional roles following mass casualty incidents.

NHQ Mass Casualty Response Unit:

The Canadian Association of Chiefs of Police (CACP) is comprised of both active and honorary members from across Canada. Through its members' police chiefs and other senior police executives, the CACP represents in excess of 90% of the police community in Canada. The CACP is dedicated to the support and promotion of efficient law enforcement and to the protection and security of the people of Canada. The CACP conducts its work through activities and special projects of a number of committees and sub-committees. One such committee is the Counter-Terrorism and National Security Commission chaired by Deputy Commissioner Mark Flynn (D/Comm. Flynn). A sub-

committee linked to this task force is the ***National Working Group Supporting Victims of Terrorism and Mass Violence*** (Mass Casualty Response Unit) led by Susheel Gupta (Gupta), the RCMP National Security senior strategic advisor.

Given the commonalities between what occurred at the JSCN and the spirit of the work being done by the sub-committee (above), D/Comm. Flynn reached out to Gupta requesting they provide support to the RCMP on the ground in Saskatchewan.

Gupta contacted 'F' Division colleagues on September 4th and was eventually introduced to Sergeant St. Germaine where information was forwarded regarding Effective Practices of family liaisons and major case management.

Assistance from sub-committee members from Alberta, British Columbia, and Ontario was offered and all travelled to Saskatchewan to assist in whatever capacity they could. When the decision was made that the Mass Casualty Response Team would travel to Saskatchewan, it was in a ***consultative role and they were not leading the response***. Once team members arrived in Saskatchewan, their mandate was initially not clear; however, became so shortly thereafter. This period of ambiguity is to be expected as this was essentially an ***'ad hoc' team that was put together to essentially provide whatever support was necessary, based on their experience.***

On the ground, some members were initially skeptical of Mass Casualty Response Unit's role but, in the end, found the team to be helpful. Members of the team partnered with the Family Liaison Team(s) and worked to meet any needs such as providing assistance for tracking victim contacts and assignments. As set out above, the Excel document that was created, captured some of the complexities that may not otherwise have been tracked, but made the organization of the victims much more efficient. Members of the Mass Casualty Response Team developed a planning document to be forwarded to the Family Liaison Team that will assist in planning for the victims longer term as well.

Gupta and his team are in the process of developing a proposal of 'Rapid Deployment' specific to family/victim/Family Liaison Officer (FLO) support models.

Recommendation 7.6 - Continue CACP Committee on Terrorist and Mass Casualty Incidents work on creating National Policy on proposed roles, responsibilities, and Effective Practices for Mass Casualty Response teams. Consider any plans and processes that are developed for human caused mass casualty/fatality incidents as

being applicable, at least in part, across "all-hazards" (severe weather, fire, public health incident, etc.)

Pre-Event Intelligence

There is a considerable amount of information in this report regarding the suspect's past criminal activity, violent behavior, and actions leading up to the tragic events of September 4th. Further, the fact that the suspect was on parole, at large, and on an outstanding warrant during the events of September 4th and the days that followed is well documented. When considered as it is compiled in this report, there may be a tendency to view the events at the JSCN and in Weldon as being more predictable than they actually were. When trying to make sense of what happened on September 4th and further, why it happened, one must take into account the full complexity of the situation.

This objective is intended to examine what, if any, intelligence regarding the suspect and/or the crimes that were committed on September 4th existed and were known by the RCMP prior to the incident. Within the context of this objective, two underlining questions were identified for review:

- Were there reasonable opportunities for law enforcement intervention with the suspect prior to their actions?
- Was there a way to detect early signals?

While it was determined that a factual account of pre-intelligence material related to the suspect and this incident could speak to the first question that was posed, the second question cannot fully be answered within the scope of this review. Answers to the second question would require an in-depth study and analysis of the suspects' complete background and would potentially involve a multitude of experts in various fields such as behavioral science, predicative analysis, criminology, psychiatric, mental health, substance abuse and addiction.

In addition to this, ***two separate reviews*** are being conducted that that may offer further insight into whether this incident could in any way have been predicted, or prevented. The first of these, the ***Correctional Services of Canada*** review (discussed earlier) will examine the suspects statutory release, community supervision, and surrounding PBC decisions.

The second review to be conducted will be led by the ***RCMP National Headquarters Behavioral Sciences Unit (NHQ-BSU)*** who were tasked by the 'F' Division MCU to conduct a ***Psychological Autopsy*** of suspect that will include a thorough examination of the incident and the suspects background in attempt to answer, in part, the following three questions related to the incident on September 4th:

- Why did it happen when it did?

- Why were those Victims targeted?
- Why did the Offender commit the crime(s) in the manner that he did?

Currently, it is not known when the results of this Psychological Autopsy and report will be available.

Based on these additional investigations/reviews being conducted, the scope of this objective has been focused so as to not duplicate their work at this time. It is anticipated that the corresponding reports from Correctional Services of Canada and the RCMP NHQ-BSU, once completed, may afford additional findings and recommendations related to this objective and the two underlining questions.

Recommendation 8.1 - It is recommended that the findings of the CSC and PBC National Joint Board of Investigation (BOI) be reviewed by the RCMP once it is available. The findings in of BOI may provide valuable additional information pertinent to and 'pre-event intelligence'.

Recommendation 8.2 - It is recommended that the findings and report of the NHQ – Behaviour Sciences Unit be reviewed once available and potentially incorporated with the OISP review with this or any other relevant objective.

Criminal History - Suspect:

The suspect was the subject of ***over 160 listed occurrences from 1996-2022*** stemming from occurrences involving the RCMP, Prince Albert Police Service, Saskatoon Police Service, Regina Police Service, Kamloops RCMP, Prince George RCMP and Delta Police. A significant number of these occurrences were related to violence.

The suspect also had an extensive ***Criminal Record*** that included convictions for Assault x10, Mischief Under $5000 x6, Fail to Comply with Disposition, Fail to Attend Court x4, Unlawfully at Large x2, Dangerous Operation of MV, Fail to Comply with Undertaking x10, Resist Arrest x3, Assault Police Officer x2, Breach Conditional Sentence Order, Assault with Weapon x3, Break Enter & Theft, Possession of a Schedule II Substance, Fail to Comply with Probation Order x7, Obstruct Police Officer, Fail or Refuse to Provide Sample, Driving while Ability Impaired, Fail to Comply with Recognizance x3, Aggravated Assault, Uttering Threats x2, and Robbery.

The most recent convictions included ***three separate sentencing dates*** of September 24th, 2018, January 23rd, 2019, and May 13th, 2019 where the ***combined sentences totalled 4 years, 4 months and 19 days***. The convictions included three counts of

Assault with a Weapon, Robbery, two counts of Mischief, Assault Police Officer, Utter Threat to Destroy Property, Utter Threat to Cause Death/Harm, and Assault.

It goes without saying that the suspect had a significant criminal history and was subject to numerous police investigations, charges, and convictions on multiple occasions.

Correctional Service of Canada and Parole Board of Canada records

As pointed out earlier, the suspect was on ***statutory release*** from incarceration but unlawfully at large for breach of his conditions when he committed the multiple murders and assaults on the JSCN and Weldon on September 4th. For clarity, an explanation is required as to what statutory release is and how an offender is granted release back into society.

Definition:

The law in Canada requires that federal offenders who have served ***two-thirds of a fixed-length sentence*** be released from prison under supervision at that point. This is called 'statutory release'.

Statutory release is a type of conditional release because the offenders are supervised in the community. Statutory release ***does not end an offender's sentence*** but instead allows offenders to serve what is left of their sentence in the community. ***They must report regularly to a CSC Parole Officer (PO) and follow conditions.*** On statutory release, offenders have some time under supervision in the community before their sentence ends to help them return to society as law-abiding citizens.

The ***Parole Board of Canada (PBC) has a role in statutory release only if CSC refers a case to the Board for review***. The Board's role is limited to:

- imposing conditions on release;
- cancelling a suspension of statutory release ordered by CSC so the offender goes back on statutory release;
- revoking the statutory release so the offender returns to prison; and
- in certain circumstances, orders that the offender be detained in CSC custody until the end of their sentence.

Conditions:

An offender on statutory release who breaches their conditions may have their statutory release suspended and be sent back to prison, if CSC considers this necessary to manage their risk. CSC will review the case and may refer it to the PBC who

will then decide whether the offender should remain on statutory release with the same conditions or with new conditions, or if the offender should have their statutory release revoked. ***As will be detailed below, this was the process by which the suspect was granted his statutory release.*** If the PBC orders that statutory release be revoked, the offender will stay in CSC custody until they next reach the two-thirds point of the remainder of their sentence, unless the Board has ordered that the offender be detained.

Review Process:

CSC may refer a case to the PBC, ***recommending that an offender be denied statutory release and be detained in prison until the end of their sentence*** if the case meets certain legal criteria. The PBC can order the offender detained if it finds there are reasonable grounds to believe that an offender is likely to commit before the end of their sentence:

- an offence causing death or serious harm;
- a sexual offence involving a child; or
- a serious drug offence.

The ***PBC reviews detention orders once a year*** until the offender completes their sentence or the Board determines it is reasonable to cancel the order and allow statutory release. For the detention order to be lifted, the Board must be satisfied that the offender no longer meets the detention criteria. ***Protection of society is the paramount consideration*** in all Parole Board of Canada decisions.

CSC and the PBC provided documentation to MCU as part of their criminal investigation into the event of September 4th. Those records were reviewed as part of this objective. The suspect's entire criminal history is not re-duplicated below but rather the ***dates and events relevant to his most recent convictions*** that led to his incarceration, ***decisions that led to his statutory release***, and ***events that led to a warrant*** being issued for the suspect for breaching release conditions are emphasized. The following is a summary of those key dates and findings relevant to this objective:

<u>January 25th, 2015:</u>

The suspect stabbed [redacted] with a knife [redacted]. [redacted]. The suspect continued to attack them until sirens were heard, and the suspect fled. The

suspect was located a short time later and eventually was convicted for a lesser offence and received a 2 year sentence.

[redacted]

July 27th, 2017:

The suspect was at a store on the JSCN, got into an argument with an employee, tried to fight him, then threatened to murder him and burn down his parents' home. The victim retreated to the store for his own safety. Police were unable to locate the suspect so he was charged and investigators ***obtained a warrant for his arrest***.

November 30th, 2017:

The suspect and an accomplice robbed a fast food restaurant in Regina while armed with a firearm. The suspect reportedly threatened his accomplice into assisting with the robbery by hitting him in the head with the firearm that was used during the offence, and stomping on his head.

April 15th, 2018:

The suspect was drinking at a residence on the JSCN, became angry and began attacking other people in the house and ultimately ***stabbed two males with a fork***. After assaulting the two males inside the house, the suspect went outside, attacked another person who was walking nearby, beating him until he lost consciousness, in a ditch. The suspect then returned to the residence and kicked in the door. The homeowner was able to eventually calm the suspect down and he departed prior to police arrival.

June 3rd, 2018:

Melfort RCMP attended [redacted] residence on the JSCN looking for the suspect. [redacted] ***stated that he was not present in the residence nor had she seen him***. The suspect was then discovered sneaking out the back window of the house. RCMP placed him under arrest; however, the suspect retreated back into the house. RCMP tried to call the suspect out but he refused and repeatedly told police they would have to shoot him. The suspect eventually exited and was taken into custody; however, while in handcuffs, he lunged at an officer and had to be restrained. While being searched, he became hostile again, and began trying to pull away from police. As the suspect was being placed into

the back of the police vehicle he kicked an officer in the head repeatedly, until police were able to place him into the vehicle.

September 24th, 2018:

In relation to the above incidents, the suspect was cumulatively found guilty on charges of Assault with a Weapon x 3, Robbery, Mischief x 2, Assault Police Officer, Utter Threat to Destroy Property, Utter Threat to Cause Death/Harm, and Assault and received a sentence of ***4 years, 4 months and 19 days***. The ***Conditional Release Expiry Date was February 12th, 2023***.

February, 2021:

While in custody, the suspect's ***security classification was reduced to minimum*** and he was transferred to the Willow Cree Healing Lodge located on the Okemasis FN in Saskatchewan, approximately 90 kilometers north of Saskatoon.

February 11th, 2021:

A PBC hearing was held regarding a ***decision about granting the suspect day and full parole***. The decision was based on whether the suspect would present an undue risk to society before the expiration of his sentence. Consideration was given as to whether release would contribute to the protection of society by facilitating reintegration into society as a law–abiding citizen.

The decision noted ***the suspect was high-risk to reoffend with violence and parole was denied*** at that time.

August 26th, 2021:

The suspect was ***discharged on statutory release*** from the Willow Cree Healing Lodge with ***conditions to report to Saskatoon Parole Office***, and to reside with his father, in Saskatoon.

November 3rd, 2021:

The suspect's PO was contacted by [redacted] that [redacted] had been living with the suspect since October (2021). The PO contacted the suspect, confirming [redacted] story and reminded him of the violation of his condition to report [redacted]. A ***Warrant of apprehension and suspension of release was issued***. ***The suspect***

turned himself in to the Saskatoon Police Service the same day. No new charges were laid.

November 17th, 2021:

As a result of the suspect's apprehension, his PO out of Saskatoon completed an ***'Assessment for Decision'*** that recommended ***the suspect's security level be increased from low to moderate***. The report outlined various justifications for the change in security level; however, identified [redacted] as the 'most significant concern'.

November 29th, 2021:

Saskatoon Parole completed another ***'Assessment for Decision'*** regarding a ***recommendation for revocation of the suspect's Statutory Release***.

Based on the circumstances outlined in the document, the suspect's risk in the community was no longer considered to be manageable and it was recommended that his release be revoked. Should the suspect's Statutory Release have been revoked, ***his next Statutory Release Date would not have been until approximately September of 2022.***

Special conditions were recommended should the PBC have decided to lift the suspect's current suspension of his Statutory Release.

February 1st, 2022:

The ***Parole Board lifted the suspension of the suspect's statutory release*** with a reprimand for failing to be open [redacted] and living arrangements***. It should be noted that CSC did not recommend the suspect's release***. The following includes notable portions contained in the 10 page, PBC Decision:

- The suspect's risk re-offend was assessed using actuarial (statistical) tools. ***The suspect scored as medium/high risk*** on one scale and in the ***high risk category to reoffend*** on the other.
- It was noted that while incarcerated, the suspect participated in programming, cultural activities, and was engaged with the Elders. He completed employment certificates and self-help courses.

Ultimately, the PBC arrived at the following assessment:

'The Board (PBC) is satisfied that that your risk is manageable in the community, if you live with your father, maintain sobriety and employment, and continue with developing supports, including getting therapy.'

'The Board (PBC) ***cancels the suspension of your statutory release*** *with a reprimand. The reprimand is that you failed to be open in communications with your parole supervisor, which resulted in your suspension; going forward, you need to be honest and open with your parole supervisor.'*

'It is the Board's opinion that ***you will not present an undue risk to society if released*** *on statutory release and that your release will contribute to the protection of society by facilitating your reintegration into society as a law–abiding citizen.'*

February 2nd, 2022:

The suspect was released from the Saskatchewan Penitentiary and contract the National Monitoring Centre advising that he had arrived at his approved residence in Saskatoon. The suspect had an appointment to meet with his parole officer the following day.

February 3rd, 2022:

The suspect met with his parole officer where they discussed the circumstances surrounding his previous suspension. The suspect denied any breach of conditions that had led to his recent suspension. The suspect spoke about the difficulties that he had, returning to custody and advised that he had a mental breakdown while in custody but learned the skills to pull himself away from thoughts of self harm and to focus of pursuing a better life in the community.

February 11th, 2022:

The suspect met with a Correctional Program Officer for Saskatoon Parole and requested the restriction preventing him from having contact with his family be lifted. The suspect felt he had been through enough programming and had learned to deal with his emotions without violence or intoxicants. He stated his actions put him in the correctional system however he has learned from this. The suspect believed the incident between himself and [redacted], that resulted in suspension, was a regular disagreement and was exaggerated. The condition was not removed on this date.

February 21st, 2022:

Information was received by the suspect's PO that he had breached a no contact order [redacted]. A Case Conference was held and the ***decision was made to maintain the suspect's release***, with a disciplinary interview.

May 24th, 2022:

There was a determination by the PO that the suspect was again, [redacted] in breach of his conditions. ***The suspect's release was suspended*** by the Parole Office and a ***warrant was issued by Saskatoon Police Service***.

NOTE: Saskatoon Police Services' records related to the suspect have not been observed as they fall outside the scope of this review. A review of RCMP PROS database was conducted and it was determined that there were no occurrences generated or cautions/flags entered on the suspect's subject persons' profile. There were also no records identified during this review to indicate that any notifications were received by the Melfort RCMP advising of the suspect's UAL warrant until the July 22nd, 2022, casework entry of another PO detailed below.

May 26th, 2022:

The suspect was advised that a warrant had been issued for his arrest and he should turn himself into the local police.

June 1st, 2022:

The suspect expressed his struggle in coming to terms emotionally with turning himself in to police in communication with his PO. The suspect said he was working up the courage to do so and wanted to call and express himself and tell his PO that he was scared and not combative about the situation. The suspect denied using intoxicants and requested placement at the Healing Lodge or a minimum security facility.

July 22nd, 2022:

The suspect's PO spoke with Melfort RCMP (no specific member noted) regarding the suspect's UAL status. The PO was advised that the last time the Melfort Detachment had recorded contact with the suspect was prior to his incarceration. The PO was advised that the detachment nightshift would check residences that he was known to frequent in the past.

There was no corresponding Melfort RCMP record relating to this contact from Sanderson's PO found on PROS or in the investigative material reviewed to date.

Warrant Enforcement Support Team (WEST)

'F' Division has a ***Warrant Enforcement Support Team (WEST)***, that came into effect in April 2022. This unit conducts law enforcement and intelligence activities with the

objective of locating fugitives who escape from custody, or became unlawfully at large by violating bail, parole or intermittent sentence terms, including those with warrants for arrest.

WEST will target high-profile offenders with outstanding warrants who represent a significant threat to public safety. The team focuses on warrant enforcement across the entire province and are based out of Saskatoon and Meadow Lake. The Saskatoon / Meadow Lake WEST team consisted of a 6-member team (Sergeant, Corporal, and four Constables) all of which were deployed to the JSCN/Weldon event.

WEST Role in the JSCN/Weldon Event:

Upon being deployed and arriving on the JSCN, WEST members were initially tasked with assisting MCU with obtaining statements for many of the witnesses to the 11 homicides. Although this was not part of their apprehension mandate, there was an abundance of information that was still being collected reading the incident and, until such time that they were tasked with apprehension efforts, the WEST team assisted wherever necessary.

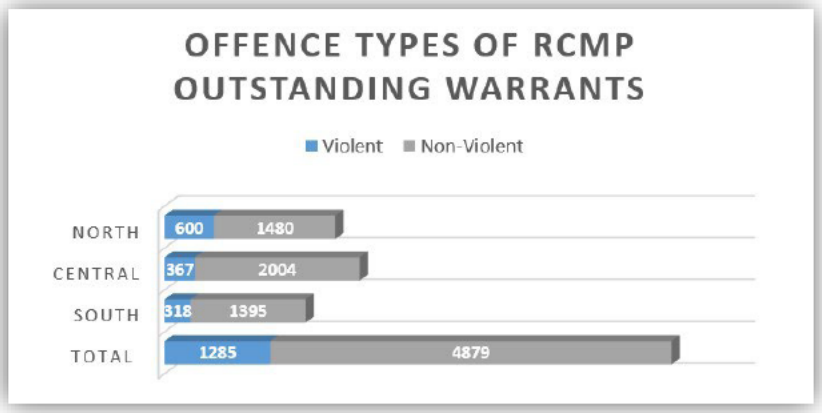
The following day (September 5th) the WEST team was back on mandate for apprehension efforts and remained as such for the duration of the event. WEST was situated in the MCU command post in Prince Albert alongside the Apprehension Team (described earlier). The WEST portion of the apprehension team in the command post included – MCU Team Commander, WEST Team Commander, a Senior Saskatchewan Enforcement Response Team (SERT) Analyst, and Affiant, and a File Coordinator. The WEST TC liaised with MCU team lead for the Apprehension Team and coordinated both the WEST and North Battleford Crime Reduction Team (CRT) resources to ensure the WEST portion of apprehension efforts were coordinated. WEST and CRT teams were working in separate locations and being coordinated and tasked by the WEST TC with direction from the MCU Apprehension Team lead (who was working in concert with CIC), in relation to apprehension. Efforts to continue apprehension continued in this fashion for the remainder of the event.

Since the JSCN/Weldon Event:

Since the commencement of this review, ***an additional WEST team has been approved for creation in Prince Albert.*** As this entire unit is relatively new, refining the methodology on how to prioritize offender selection and enforcement is ongoing. WEST does not have an embedded analyst; however, receives analytical support from the 9 analysts that fall within the SERT organizational chart.

[redacted]

This prioritization is essential as it was found that as of ***October 7th, 2022***, the statistics for outstanding RCMP warrants was as follows:



The above statistics include only RCMP warrants. As the suspect's warrant was issued out of Saskatoon Police Service it would not have been included in the RCMP stats at the time.

The ***Intelligence Manager for F-Div – Saskatchewan Enforcement Response Team (SERT)*** receives an UAL list that is regularly distributed by CSC. The UAL list includes the agency that laid charges, release addresses and who is the Police of Jurisdiction. Steps are taken, where possible, by the Intelligence Manager to determine if a broadcast should go out to a certain RCMP jurisdiction. Due to the large volume of warrants/UALs, broadcasts are not sent out on every subject.

Related Past Casualty Review Recommendations:

Upon review of the ***MacNeil Report*** a similar objective to this one was found in their report and titled 'Section 11: Perpetrator /Information/Intelligence/ Prevention Opportunities' and ***included the same two underlining questions*** (listed above) with the below recommendation:

Recommendation from the MacNeil Report (Moncton 2014):
11.1 - The Review recommends the RCMP consider broadening its support for initiatives that support young people with mental illness.

Based on the material available to this review, there were no specific RCMP supported initiatives that the suspect was identified as having been involved in and/or accessing.

It was noted, however, that 'F' Division had undertaken recent initiatives focussed on improved police service related to mental illness. An example of this was from June 8th, 2021 where Saskatchewan RCMP positioned two psychiatric nurses to its OCC to assist RCMP members in real time during mental health interventions with the public.

Although the suspect had not been involved in any RCMP supported programs/initiatives, he was found to have been involved in several programs while under the supervision of CSC, included the following:

- attended the Metis Addiction Council of Saskatchewan Institute's six-week day program in 2013 and received further outpatient treatment in 2015 and inpatient treatment in 2016;
- While incarcerated, participated in:
    - Programming and cultural activities, engagement with Elders, completed employment certificates and self-help courses;
    - completed the Non Intake Indigenous Primer and the Indigenous Multi Target High Intensity Program;
    - Completed the Wastew Pimatisiwin: Shining Life (Grief Program);

Following the suspect's release into the community, he commenced the Indigenous Integrated Correctional Program Model (ICPM) Community Maintenance Program in October 2021, but was unable to complete the program due to his release being suspended in November 2021. Reports on file noted that he completed six sessions of the program in the community and failed to call in for four other sessions, prior to being suspended.

Mental Health, Community Safety and Initiatives Going Forward

Since the commencement of this review, Federal funding has been announced that could result in initiatives that are in line with the spirit of this objective and present opportunities for RCMP involvement.

On November 28th, 2022, the Government of Canada announced committing ***$62.5 million over six years to support the healing, mental health, and well-being of community members*** impacted by the tragic events of September 4th, and to support Indigenous-led approaches to community safety.

The news release from the Prime Ministers Office included the following:

- ***$42.5 million*** *to help support mental wellness and healing, including through the* ***building of a new wellness centre*** *in the community and repurposing the existing Sakwatamo Lodge. It will also enable JSCN to* ***develop and design programs that best serve the needs of their members*** *including increasing access to mental health, trauma, and substance use services;*
- ***$20 million over four years*** *towards the* ***Pathways to Safe Indigenous Communities Initiative*** *supporting JSCN and other communities in developing and delivering community-based safety and wellness projects;*
- ***$300,000*** *to address the* ***specific mental health needs of children*** *at the JSCN School;*
- *In October, the Government of Canada, the Government of Saskatchewan, and the Prince Albert Grand Council announced a partnership with the aim of* ***improving public safety and policing*** *in its 12 member First Nations and 28 communities. This team will advance work on* ***Indigenous-led public safety initiatives****, tailored to the needs of each community.*

Recommendation 8.3 - It is recommended that the RCMP continue to support and engage, wherever possible, the proposed community safety, mental health and other related initiatives undertaken in the wake of the events in the communities of JSCN and Weldon.

Summary

A mass casualty event such as this has a lasting impact on whatever community it occurs in, no matter the size. In the case of the JSCN and Weldon, the impact is augmented due to their respective communities having such small populations. The events that occurred on September 4th affected entire communities. Every member of the JSCN and Weldon communities either knew the victims or were related to them and have been reminded of those events on a daily basis. The harm that was caused will last for generations.

The appreciation for the citizens of the JSCN and Weldon has been recognized throughout this review. From the steps that were taken by community members from JSCN and Weldon at the onset of the events on September 4th, to working with the RCMP during the days that followed, to the aftercare steps that were taken for the victims, to making themselves available for interview as a part of this process, their resiliency has been commendable. The events of September 4th highlighted the real threats that communities and police agencies across Canada face daily and the need to work together to promote public safety.

It is our hope that by conducting this review, identifying lessons learned, and providing recommendations moving forward, that we can provide insight and promote positive change for the RCMP and other municipal police agencies across Canada.

Summary of Recommendations

Recommendation	Level of Responsibility
Initial Response	
1.1 - Consider Divisional and / or National level policy direction and/or training around the issue of one or two-person patrol vehicle responses. Include a discussion of the risks relating to the separation of resources, when there are only two members to respond. Policy and/or training should not be prescriptive, but rather framed in a way that can assist members to best consider the risks and make the most effective decisions accordingly.	Division and National
1.2 – The Detachment Commander should encourage other members to attend the JSCN, whether on patrol or for events in order to create relationships with the community.	Detachment
Command Structure	
2.1 – Consider splitting Mobile CP resources to have equipment available for deployment in a more northern location.	Division
2.2 - On large scale incidents it is critical that the CIC is directly embedded in the ICP or linked in via technology to be sure there is full situational awareness with all commanders.	Division and National
2.3 - Physical relocation of the ICP to a location closer to future events of this scale should be considered as a measure to alleviate some of the communication gaps experienced. Alternatively, should it be decided by command that the ICP should be located in the DEOC, provide a clear announcement advising of that designation.	Division and National
2.4 – Consider designing a 'crimes in action' protocol for the Division that includes organizational chart templates for roles necessary to fill, should an event of this magnitude transpire again. This would promote an organizational structure to be present at the onset of the event. Within this structure, roles and appropriate reporting lines between the DEOC, CIC, MCU, etc. can be outlined.	Division and National

2.5 - Commit to and implement a major event command system for the division. Liaise with counterparts in other divisions to explore their standardized systems. Explore and support appropriate training at all levels of membership. Include National Operational Readiness and Response unit to ensure the greatest consistency around implementation.	Division and National
2.6 - Consider options to modernizing the DEOC. Examine feasibility of re-organizing or re-locating the DEOC, including investment in technology and infrastructure.	Division
2.7 - Identify division scribe resources and managers and explore the possibility of a scribe program that will automatically dedicate a scribe to CIC call outs.	Division
2.8 - Consider requesting a resource from NHQ to travel immediately to the location of a potentially prolonged major incident to take on the role of National/Division liaison.	Division and National
2.9 - Continue investment in Common Operating Picture software. Continue efforts toward installation and training on ATAK or some type of system that allows for tracking of resources. Ensure the DEOC is considered in any technological upgrades.	Division
Air Services	
3.1 - For any major events requiring air assets, the Divisional Flight Coordinator or an Air Boss should be identified immediately and situated in the ICP alongside command.	Division and National
3.2 – 'F' Division Air Services and the Critical Incident Program should practice together at least twice a year (1 day and 1 night) to maintain proficiency for ERT members and to better recognize the capabilities and limitations of each unit.	Division and National
3.3 - Resolve the interoperability issues with Air Services communications and GPS systems to work seamlessly with ERT communications and equipment (ATAK).	Division and National
Major Crimes Branch Response	
4.1 – Explore the possibility of a scribe being assigned to the Command Triangle to capture decision making and content from briefings.	Division

4.2 – Assess the feasibility of having embedded analytical support for MCU teams as a standard procedure, for all major incidents.	Division
4.3 – Consider the creation of a MCU logistics package for expediting set up on initial call outs.	Division
4.4 – Explore the possibility of leveraging civilian resources to support the processing of high volume exhibits. Have someone permanently at the exhibit room receiving exhibits.	Division
4.5 – Explore opportunities for FLS to lead presentations to MCU to relay the capabilities of their services, particularly in regards to mass casualty events, and to form a basis for discussion between the units.	Division
4.6 - Consider purchasing inflatable tents or fabric walls for FIS to protect hold back evidence and provide more dignity to the deceased while processing scenes.	Division
4.7 – Consider making the Basic Bloodstain Pattern Recognition Course mandatory for all FIS members.	Division and National
4.8 – Nationally, FIS should explore the feasibility of 'civilianizing' some BPA positions in order to alleviate some of the resource strains.	National
Strategic Communications	
5.1 – 'F' Division should support any potential system updates that may promote efficiency and continue to identify any methods to streamline the process of data input into the NAAD System.	Division
Operational Communications	
6.1 - If not included in formal training, any 'in-house' training sessions or briefings should highlight the potential issue of staying on the phone longer than necessary in an emergent situation where OCC is experiencing a high volume of calls.	Division and National
6.2 – At minimum, in the case of a major incident where higher call volumes will be received in the OCC, assign a MCU Investigator, an Analyst, and an OCC Supervisor to monitor and analyze the incoming calls in real time, to best identify and determine trends,	Division and National

patterns, or clusters of calls that might otherwise not be identified in isolation.	
6.3 - Continue to work with the Province of Saskatchewan and the JSCN Band Council to address radio communication shortcomings.	Division
6.4 - Update CIIDS Software to include a mapping system and the ability to share vital information as perimeters and location data.	Division and National
Mass Casualty / Victim Response	
7.1 - Promote direct contact between the family liaison and the media liaison (or via the MCU CT) in order they consider the impact of scheduled media events on the various investigating units, including the Family Liaison Teams.	Division and National
7.2 - Consider seeking out additional training for select members and/or supervisors in the area of mass casualty events. Training should include recommended deployment and reporting structures, documentation processes, and the function of Family Liaisons during events such as these.	Division and National
7.3 – Recommendation 7.3 – Drawing on experience from this event, consider generating some type of 'Legacy Document' to be disseminated divisionally, outlining various cultural considerations that are necessary to provide appropriate support for victim families.	Division and National
7.4 – Based off experience from this event, National consideration should be made for the development of Mass Casualty or Mass Fatality 'Victim Support kits'. This kit could include guiding documents, pre-printed victim support pamphlets (in multiple languages), and program referral links. These kits could be stored electronically and/or pre-assembled at a District or Divisional level.	Division and National
7.5 - Employees of Victim Services should receive the same access to Critical Incident Stress Debriefing and Wellness programs in recognition of their ongoing, primary functional roles following mass casualty incidents.	Division and National
7.6 - Continue CACP Committee on Terrorist and Mass Casualty Incidents work on creating National Policy on proposed roles, responsibilities, and Effective Practices for Mass Casualty Response teams. Consider any plans and processes that are developed for human caused mass casualty/fatality incidents as being applicable,	National

at least in part, across "all-hazards" (severe weather, fire, public health incident, etc.)	
Pre-Event Intelligence	
8.1 - It is recommended that the findings of the CSC and PBC National Joint Board of Investigation (BOI) be reviewed by the RCMP once it is available. The findings in of BOI may provide valuable additional information pertinent to and 'pre-event intelligence'.	Division and National
8.2 - It is recommended that the findings and report of the NHQ – Behaviour Sciences Unit be reviewed once available and potentially incorporated with the OISP review with this or any other relevant objective.	Division and National
8.3 - It is recommended that the RCMP continue to support and engage, wherever possible, the proposed community safety, mental health and other related initiatives undertaken in the wake of the events in the communities of JSCN and Weldon.	Division

Summary of Effective Practices

The following is not a comprehensive list of all effective practices that were displayed throughout the RCMP response to the JSCN/Weldon event. Documented within the body of this report were several accounts of responders (both police and civilian) performing duties in an exemplary fashion that may not be documented below. The intent is not to minimize those efforts but rather to draw attention to specific practices that are more widely applicable.

Command Structure – MOSS Unit
Have a list of back line numbers for various agencies and units to facilitate direct contact, especially during the early morning hours when most are not working or at their regular contact numbers.
Command Structure - Duty Officer and Criminal Operations Officer involvement
'F' Division maintains an on-call Duty Officer program, where Commissioned Officers are rotated through a schedule to cover any significant issues or incidents. 'F' Division maintains a Duty Officer matrix used by the MOSS Unit that outlines threshold for when notification is necessary.
Command Structure - Division Emergency Operations Centre (DEOC)
Although not all roles were utilized, planning for these roles within the DEOC were considered as required. For future events, exploring call-out system options, generating a 'call out list' of division employees who can fill the various roles, and/or supporting appropriate training would continue to support efficiency of staffing this resource requirement.
Command Structure – CIC Support
Although not required, the involved CIC's had their portables and laptops at their residences, allowing the incumbent CIC to have the highest level of situational awareness at the time of transferring command.
To assist with efficient deployment of the ERT CP, the Critical Incident Support Unit in 'F' Division is scheduled to on-call rotations and take direction from the CIC.
Major Crimes Branch Response – Initial MCU Response and Assignments
Due to the nature of what was transpiring on the JSCN and in Weldon, additional 'Team Lead' positions were created in real time in order to delegate the crucial investigative roles that were anticipated given the circumstances.
As early as possible, given the size and scope of an investigation, identify crucial lead roles and delegate appropriate investigators to assume those positions. The creation

of these roles allows for more efficient flow of information to the TC and PI and for more focussed tasking.
Major Crimes Branch Response - Forensic Identification Services (FIS) Response
Having a FIS resource in the office allows for immediate responses to emergent situations.
Be mindful of the possibility of another deployment and the need for resources to be made available for the same.
Use of support units and Provincial resources for added scene security.
Providing at minimum, regular unprompted National level daily updates for major events.
Strategic Communications
OCC alerted RCMP members of the Public Alert prior to it being disseminated in the event they were in a compromised position (i.e. hiding or about to engage a suspect)
Regular practice sessions with Senior Officers dealing with issuing public alerts as per RCMP Policy.
A specified Media employee was tasked with answering the media phone line and tracking the media calls. This gave reporters the ability to speak to an actual person, rather than a listen to a recording during the event.
Having the CO taking responsibility of the media portions and had well planned media strategy.
Local media requests were given precedence for providing interviews over non-regional or international media.
Establish media relationships with various municipal agencies in the event that collaboration is required.
Continued liaising with municipal counterparts and in other divisions in order to expedite assistance in times of critical need.
Operational Communications
Even during times of significant increases in call volumes, despite that the length of times on calls might have been reduced in the circumstances, the OCC call takers and dispatchers continued to take complaints and dispatch calls for service to the appropriate areas of responsibility, i.e. Detachments of jurisdiction.
Promptly assigning an operator specifically tasked to manage calls related to JSCN and Weldon, while others in the OCC were tasked with any unrelated calls in their geographic areas of responsibility.
Mass Casualty/Victim Response
Assigning the functional role of family liaison to deceased victims' next of kin should be done as early as possible by the Team Commander.

The ratio of number of points of contact or family members assigned per Family Liaison should be kept as low as possible and consideration given to those roles that will require more time and sensitivity.
Family Liaison Team Managers/Supervisors should co-locate with the Command Triangle or Investigative Team to support communication.
Requesting out of division IPS resources to increase needed capacity in this area, and embedding a culturally appropriate representative within the EOC in order to be the direct line of communication between the Band and RCMP.
The digital tracking and documentation of victims deceased and injured, their next of kin or family contact information, and relationship is critical. A digitally formatted document for ease of updating and sharing between investigators, family liaisons, and Victim Services is recommended.

Appendix "A" – Mandate Letter

Royal Canadian Mounted Police
Commanding Officer

Gendarmerie royale du Canada
Commandant divisionnaire

To: C/Supt. Kevin Kunetzki
Deputy Criminal Operations Officer
"K" Division

Security: Pro A
Operational File: 20221271697
Review File: 236-208-015
Date: 2022-09-22

From: A/Commr. Rhonda Blackmore
Commanding Officer
"F" Division

Re: Directed Review - James Smith Cree Nation Mass Casualty Incident

On Sunday, September 4, 2022 at 0540 hrs, members of the Melfort Detachment responded to multiple calls of stabbings that had occurred at several locations on the James Smith Cree Nation. Myles Sanderson and Damien Sanderson were identified as suspects in the stabbings, resulting in several emergency alerts being broadcast. CIC and ERT were activated leading to a provincewide manhunt that ended with the discovery of Damien Sanderson being deceased and Myles Sanderson later being captured near Rosthern, Saskatchewan on September 7th. Shortly after capture, Myles Sanderson went into medical distress where he was eventually pronounced deceased.

In accordance with "F" Division Administration Manual Ch. 26.100 Internal Reviews, I request that you conduct a Directed Review into the following areas of this incident; and if applicable, provide any recommendations at both the Division and National level.

In addition to any other areas you may wish to examine and provide recommendations for, I request that you specifically examine the following areas within your review:

1. Review tactics and response to the initial call on September 4, 2022
    a. Does the manner in which the members were dispatched and coordinated in their response to this call suggest any improvements can be made in RCMP training, policy, or other areas?
    b. Was there clarity with regards to the Critical Incident Command structure? Was there the ability to process critical information in a timely manner for the Incident Commander throughout the event? Were there sufficient briefings between the outgoing and incoming incident commander?
2. Supervision during the entire incident. Does the manner in which the incident was supervised suggest any areas for improvement, including but not limited to:
    a. Local supervision,

b. Duty Officer, and;
c. Senior Leadership.

3. Emergency Response Team (ERT)
   a. How was the evolving ERT/coordinated response managed?
   b. Review of the ERT After Action Report:
      i. Is there a need for a more detailed report by ERT for significant events than just the form 1225 for ERT Debrief which is a basic, fill in the blanks template? Is there an opportunity here to develop the framework to be used for major incidents and mass casualty events that require more detail than what can be captured on the 1225?
4. Equipment and Weapons
   a. What was the state of availability of equipment and force approved use of force options being used?
   b. What other equipment or weapons would have been of assistance?
5. Availability of specialized equipment and units
   a. Examine the availability of specialized F Division resources.
   b. Examine the ability to acquire additional services from other Divisions, such as Air Services, [redacted], ERT, STO, Victim Services, and General Duty Members.
   c. In addition to availability, did the specialized units have the appropriate/current technology?
6. Crime Scene Management
   a. Were FIS resources adequate?
   b. How were FIS resources coordinated to ensure that all crime scenes could be examined in a timely and thorough manner?
   c. What efforts were made to protect all evidence from outdoor scenes to ensure it was not lost due to weather?
   d. Were bodies removed as early as possible so they did not have to remain at scenes, especially the outdoor scenes?
   e. What efforts were made to ensure all crime scenes and victims were located as quickly as possible?
7. Operational Communications:
   a. How was the communication between members, supervisors, ERT, and other coordinated response teams?
   b. How was the radio operability? Did radios operate as expected? Were there any issues with members not being able to communicate critical information immediately on the radio?
   c. How did OCC cope with the multiple calls for service and coordination of response?
   d. Would the availability of other forms of communication besides cellular telephone and/or radio have been of assistance?
   e. Was there adequate radio and cellular coverage in the area? Throughout the event, including the takedown of the suspect?
8. Communications/Media
   a. How did the media communications unfold? Were there regular media conferences?
   b. Was a Strategic Communications advisor in the command post?

c. What role did social media play? What platforms were used (Twitter, Facebook, others)?

9. Emergency Alerts
   a. How effective was the use of emergency alerts?
   b. Were public alerts done in a timely manner with sufficient information to ensure the public was aware of the seriousness of the situations?
   c. Is there room for improvement?
10. Division Emergency Operations Centre
   a. Examine the operation of DEOC in this incident to determine if any improvements may be necessary.
11. Perpetrator Information/Intelligence
   a. Were there reasonable opportunities for law enforcement intervention with the accused's prior to their actions?
   b. Is there a way to detect early signals from others like the accused's?
12. Investigational Response
   a. Examine the response and coordination of the Major Crimes Unit and Major Case Management Principles - National Office of Investigative Standards and Operations to conduct an IFA.
13. Victim Support
   a. Examine the response, acceptance, and effectiveness of the NHQ Mass Casualty Victim Service Unit, Local Victim Services, Family Liaison, and Indigenous Policing Services.
   b. Was the response and investigative actions culturally sensitive and respectful of the families and community?
   c. Were crime scenes held until arrangements were made for scenes to be cleaned and only released once cleaned?
14. Broader Policy Review
   a. Are there any areas where current policies, procedures, or tactics were not followed? Are changes required?
15. Interoperability and Information Sharing with External Policing Partners
   a. Were other police forces engaged in a timely and effective manner in order to maximize all available resources throughout the mass casualty event?

You may attend any scene of the incident if you feel it will be of benefit to your review. You may also review the investigation and other documentation and interview members or witnesses, providing it does not interfere with the criminal investigation.

The Commanding Officer "F" Division will cover all incremental costs and salary costs incurred in the completion of this review. Please charge any costs to F0367, IO 751780.

I ask that your report be completed within 90 days unless there are extenuating circumstances. If during the course of your review any additional practices or incidents that do not meet the expected standards of the organization are found, please ensure these are included. Supt. Grant St. Germaine will be your

liaison with F Division. Please feel free to contact him to assist in gathering the required information complete your review.

A/Commr. Rhonda Blackmore
Commanding Officer
F Division

Appendix "B" – OISP Response Letter

F Division Mass Casualty – September 4, 2022
Independent Investigative Practices Assessment
Awareness Letter

Mailing Address:
11140 109 Street
Edmonton, AB, T5G 2T4
(780) 509-3582

Date: September 28, 2022

A/Commr. Rhonda Blackmore
Commanding Officer
F Division

RE: Investigative Practices Assessment – James Cree Nation Mass Casualty Event

This Awareness Letter is to inform you that I have received your request to conduct a review of the tragic mass casualty event which transpired on the James Smith Cree Nation in September of this year. Under my guidance and direction, I have tasked the "K" Division Office of Investigative Standards and Practices (OISP) with organizing and structuring this review. The overall purpose, as I interpret your Mandate Letter dated September 22nd, 2022, is to identify what went well, areas for improvement, and determine best practices and recommendations to inform future responses both divisionally and nationally.

I provided your Mandate Letter to the Assessment team, in which you outlined 15 separate areas for review. Upon a thorough evaluation of that request, nine overarching objectives have been identified by OISP. We will address each of these areas and more through the process of conducting an Investigative Practices Assessment (IPA). These objectives are:

1. Initial response
2. Critical Incident Command response
3. Serious Crimes Branch Response
    a. Specialized units available
    b. Crime Scene Management
4. Strategic Communications
    a. Contract Partners (Government of Saskatchewan, community leaders)
    b. Media

   c. Member communications
5. Operational Communications
   a. Alerts
   b. Interdivisional communication
   c. External police agency
6. Mass Casualty / Victim Response (incl Family Liaison)
7. Command Structure implemented (including DEOC)
8. Pre-Event Intelligence (Offender / Other)
9. Policy and Prior Events Analysis

Objective 9, Policy and Prior Events Analysis, is an objective that will be incorporated within each of the individual objective reports. It is imperative that the review team assigned to this assessment be mindful of recommendations made during previous reviews following other significant and relatively recent tragic events in Canada. This will assist in determining where the organization has improved, which relevant recommendations were implemented within the scope of this incident, or not, and/or where recommendations can be identified as best practices for organizational progress. Examples of recent situations to be considered include the British Columbia McLeod/Schmegelsky homicide (and subsequent search for the offenders), the Moncton RCMP involved shooting incident, and the recent mass casualty event in Nova Scotia (where information might be available).

This Investigative Practices Assessment will be conducted by several guiding principles:

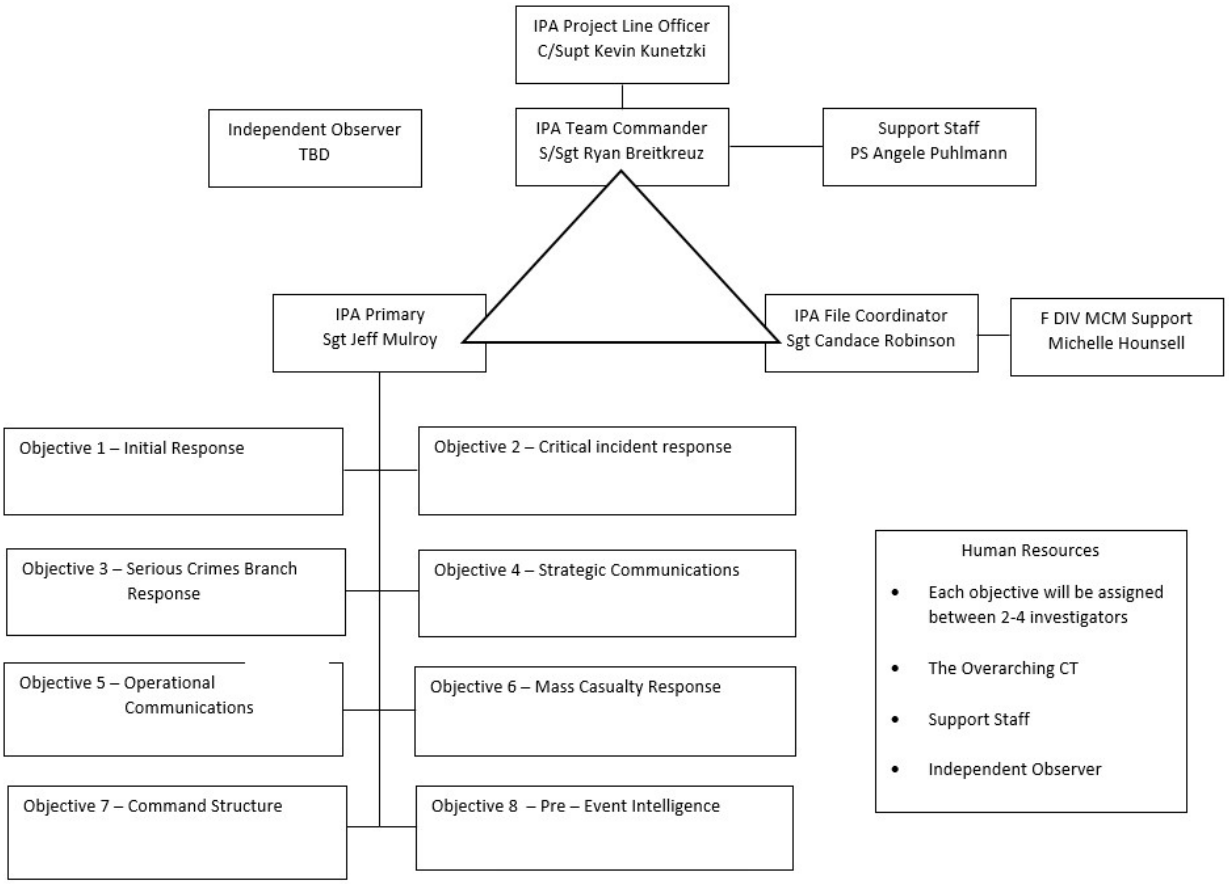
- Assess specific objectives as outlined above, and examine the effectiveness of structures in place; as well as the processes/strategies to drive the investigation forward toward the desired objectives/goals, management of the incident, and accountability mechanisms.
- A multi-discipline and multi-agency framework will be used to review the objectives.
- The Command Triangle will be structured using members from "K" Division OISP. One of OISP's primary mandates is to provide independent oversight for major project investigations.
- The review will include the incorporation of an Independent Observer to ensure transparency of the information gathered and reviewed, with the goal to strengthen stakeholder trust in the findings of this Investigative Practices Assessment.

The Independent Observer will be authorized to observe all aspects of our review, including any briefings or debriefings, any material collected in the course of the review, the mandate letter, and our final report. The Independent Observer will also be free to provide any comments or feedback to the Command Triangle or to myself directly. A key to selecting the most appropriate person will be to identify an Independent Observer who can ensure cultural sensitivity and perspective and also knowledge of police operations. In

consultation with Departmental Security, and to ensure the protection of confidential and private information, I was advised to complete a Non-Disclosure-Agreement for the Independent Observer. "F" Division Operations Strategies Branch has been engaged, and they will assist us with this aspect of our review. I will be identifying the Independent Observer in further consultation with the "F" Division Criminal Operations Officer and the Officer in Charge "F" Division Indigenous Policing.

The review of this incident will be structured using Major Case Management Principles, and a Command Triangle will be established by OISP, reporting directly to me. With transparency being key during a review such as this, in addition to the Independent Observer, some municipal policing agencies will be included in this review to supplement the required investigators needed. Each objective will be assigned its own small team of investigators in order to ensure a fulsome review of the material is completed. The following organizational chart outlines the required resources to achieve success during this review within the timeline provided. The Team Commander from OISP, S/Sgt Ryan Breitkreuz, will contact identified "F" Division representatives to coordinate the commencement of the Investigative Practices Assessment.

F Division Mass Casualty Investigative Practices Assessment (IPA) Organizational Chart



At the conclusion of our review, an Independent Investigative Practices Assessment report will be completed, based on the aforementioned areas of review. However, prior to the report being finalized, myself and the Command Triangle members will meet with "F" Division Senior Management to discuss initial observations and ensure that identified best practices and recommendations included in the report have been fully examined to the intent of your mandate letter.

In preparation for the Investigative Practices Assessment, the OISP Team Commander will contact Supt. Grant Germaine to request any information and to identify the appropriate "F" Division representatives who can assist us with completing our review. Access to the file dataset(s) will be also be requested once the review team has been fully identified.

Projected Timeline:

- Mandate Letter for the review (September 23, 2022)
- Identifying resources / logistical preparation / objective requirements (September 23 – October 14, 2022)
- In Person review in "F" Div (1 week October 16 – 22, 2022)
- Remote review (2-3 weeks October 24 – November 10, 2022)
- Review Team Briefing (1 week November 14 – 18, 2022)
- Briefing with "F" Div Senior Management (during the week of November 21-25, 2022)
- Follow up and completion of outstanding tasks (3-4 weeks November 28- December 23, 2022)
- Final report (5 weeks January 27, 2023)

Note: This timeline is subject to change depending on operational requirements. The timeline encompasses 18 weeks from start to finish, including prep and logistics, and ending with the final report which will include best practices and recommendations.

If you have any questions or concerns, please do not hesitate to contact me at anytime.

Yours Truly,

C/Supt. Kevin Kunetzki
Deputy Criminal Operations Officer
"K" Division