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October 12, 2022

Via E-Mail

Mass Casualty Commission
310-1791 Barrington Street
Halifax, NS B3J 3K9

Dear Commissioners:

Re: Final Submissions

Please accept the following submissions on behalf of the family of Peter and Joy Bond. Peter and Joy Bond were killed in their home at 46 Cobequid Court, Portapique, on the night of April 18, 2020. Throughout this inquiry we have worked closely with Peter and Joy's two sons, Harry and Cory Bond

This paper is divided into five sections with recommendations following each section. The topics we discuss are:

1) Identification of Critical Incidents
2) Immediate Action Rapid Deployment (IARD)
3) General Scene Security
4) Next of Kin notification
5) And the perpetrator's history with some forward looking recommendations

Identification of Critical Incidents

In this section, we consider the RCMP process to identify Critical Incidents, take command and control of the event and the subsequent roll out of Critical Incident resources referred to as the Critical Incident Package. We identify delays that occurred with this identification and roll out on April 18, 2020 and make recommendations to improve this service delivery in the future.

The RCMP tactical operations manual define a Critical Incident as an event or series of events which by their scope and nature require a specialized and coordinated tactical response.[1]

The Risk Manager Program, established in Nova Scotia in 2006, provides full time support and guidance to front line RCMP officers engaged in activities including Critical Incidents. The Risk Manager is embedded within the Operational Communications Centre (OCC) and is required to monitor 911 calls and dispatch resources as needed. When faced with a Critical Incident, the Risk Manager will immediately take over command and control and direct the response.[2]

At the OCC, the responsibility to recognize an event as a Critical Incident resides with the Risk Manager. This determination is a key prerequisite to requesting the deployment of the Critical Incident package which includes resources such as the Emergency Response Team, Emergency Medical Response Team, Crisis Negotiation Team and Police Dog Services.[3]

During this mass casualty in April 2020 in order to activate the Critical Incident Package, the request had to proceed through four levels of command which consisted of Risk Manager S/Sgt. Brian Rehill, Northeast Nova District Acting Operations Officer, S/Sg/t Steve Halliday, On Call Critical Incident Commander S/Sgt. Jeff West and finally Support Services Officer Supt. Darren Campbell who then approved the Critical Incident Package.[4]

In order to engage with RCMP National Headquarters, three additional levels of command had to be involved, namely, Chief Superintendent Chris Leather, Assistant Commissioner – NS, Lee Bergerman and Deputy Commissioner Brian Brennan who didn't learn of this unfolding mass casualty until April 19th, 2020 at or near 11:00 a.m. after the death of Constable Stevenson.[5]

- **April 18th 2020 Chronology**

On April 18, 2020 at 10:01:07 p.m. Jamie Blair phoned 911 and reports that her husband was shot by their neighbour Gabriel who is a denturist. She reports that her husband was lying face down on their deck and that when she went out to check on him, the neighbour was advancing up the deck with a big gun. Ms. Blair advises that she is hiding in the back bedroom with her children. Ms. Blair then reports that the shooter just broke her lock. The call ends with the sound of gunshots, crying and screaming. Ms. Blair sounds terrified and genuinely afraid. During the course of the call Ms. Blair confirms her first name, cell phone number and address of 123 Orchard Beach Drive, Portapique. Ms. Blair also confirmed that there was a police car in her driveway but that (he's) not a police officer.[6]

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[1] c1.1 Incident Commanders: Comm0018405 and H Division Tactical Operations Manual c.7.1. Critical Incident Program Activation, updated January 12, 2022: Comm0059130.

[2] H-Division Risk Manager Program: Comm0043160

[3] Foundational Documents RCMP Emergency Response Team at para 30: Comm0057766 and RCMP Command Post, Operational Communications Centre and Command Decisions at para 20: COMM0061298

[4] See NS RCMP presentation to Mass Casualty Commission for timeline of events: COMM0062662

[5] Mass Casualty Commission Interview of Lee Bergerman: COMM62441 at page 14

[6] Mass Casualty Commission's transcript of Ms. Blair's recorded 911 call: Comm0003870.

By 10:04:08 p.m. the call with Ms. Blair was disconnected after the call taker heard open line screaming and sounds consistent with gunshots. Subsequent efforts to reach Ms. Blair were unsuccessful.[7]

There were four general duty RCMP members on shift on April 18, 2020. However, no members were at or near Portapique. The members, all driving separate vehicles, were dispatched by OCC to respond to the call at 22:04:23, 22:05:00, 22:005:40 and 22:04:48 p.m and took between 21:41 and 29:04 minutes to arrive near the scene of the 911 call.[8]

After the 911 call, S/Sgt. Rehill was able to confirm that there was nothing on the Police Reporting and Occurrence System (PROS) for the address provided by Ms. Blair, that the caller could not be reached during attempts to call Ms. Blair back, that the 911 caller's voicemail belonged to a person named Jamie corroborating the first name provided to the 911 call taker, that the cell phone subscriber information came back to a Jamie Blair, that the address provided by Ms. Blair matched an actual civic address viewable by members on their Mobile Work Stations and the fact that the caller may have been a witness to a previous homicide of a biker gang member.[9]

At 10:16 p.m. 911 dispatch receives a call from the Blair and McCully children located at 135 Orchard Beach Drive and learn that this address is next door to Ms. Blair's address. The children report that the Blair parents had been shot, that the dad is outside and that the mom is in her bedroom (which matches the description of events provided by Ms. Blair), that Ms. McCully was now missing, that the perpetrator was driving a police car (which also matches a detail provided by Ms. Blair) and that the perpetrator was setting homes on fire. The children advise that they can see fires within Portapique. The children also advise that the subject of complaint was a lone male and that he had a "massive gun." [10]

By 10:27 p.m. responding members report that they can see smoke, large fires and note that a house is fully engulfed in flames.[11] At 10:28 p.m. Constable Beselt, one of the four responding RCMP officers, notes that he just encountered shooting victim survivors Andrew and Kate MacDonald.[12]

At this point in time, the Risk Manger has yet to call for tactical resources, issue commands to the general duty members or to request activation of the Critical Incident Package.

By 10:33 p.m. responding members had made their way to the head of Portapique Beach Road and were proceeding down Portapique Beach Road on foot which was the perpetrator's direction of travel in his motor vehicle.[13] It is understood that three members proceeded on foot without

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[7] Overview of calls from OCC: Comm002902. Also see timeline, *supra* note 4 at page 35.
[8] Timeline, *Supra* note 4 at page 42.
[9] Colchester radio transcript, pages 1-3: COMM006825. It is unclear exactly when the OCC was able to corroborate the information discussed above but based on the radio transcript, it appears that this information was confirmed no later than 10:17 p.m.
[10] Transcript of recorded 911 call of AD/AB: COMM0052008.
[11] Colchester radio *Supra* note 9 line 198-201
[12] Colchester radio *Supra* note 9 line 208
[13] Colchester radio *Supra* note 9 line 250

the aid of backup, night vision capabilities, FLIR, proper mapping equipment or GPS to mark their location for other first responders.

At 10:35p.m. the Risk Manager contacted Northeast Nova District Acting Operations Officer, S/Sg/t Steve Halliday, who in turn contacted On Call Critical Incident Commander S/Sgt. Jeff West who then contacted Support Services Officer Supt. Darren Campbell to approve the Critical Incident Package. The Critical Incident Package was authorized at 10:46 p.m.[14]

The Emergency Response Team was called out at 10:45 p.m. and arrived on scene with their Tactical Armoured Vehicle at roughly 1:00 a.m. on April 19, 2020.[15]

- **Delay in activating Critical Incident Package & Command and Control**

Once an event is recognized as a Critical Incident it invites a request for support services to assist in the crisis. This recognition along with the accompanying request for support services must be made as soon as possible to address the threat thus mitigating future public harm and maximizing the possible benefit for the area in need of such services. There is also an obvious benefit in the public's confidence in its police force when resources are dispatched without delay.

The request for the Critical Incident package includes the provision of tactical team support such as the Emergency Response Team, a team noted by Spt. Campbell to far exceed the capabilities of a general duty team given their training and equipment on hand.[16] During the course of this inquiry we heard that the ERT team resources include a Tactical Armoured Vehicle, night vision capabilities, FLIR and drones. In an unfolding active shooter scenario, it is imperative that these resources be dispatched as soon as possible.

In addition to the obvious benefits that flow from activating the Critical Incident Package, it requires the Risk Manager to take immediate command and control over the situation, deploy resources, and direct the response in all respects until the Critical incident Commander is in place.[17] Identifying an event as a Critical Incident necessitates an active approach by the Risk Manager and sets the tone for all those involved.

On April 18, 2020 after Ms. Blair's call ended, the incident was not deemed to be a Critical Incident right away and there was no command and control of all available resources. For example, at 10:06 p.m. Corporal Jamieson says via the Colchester Radio "once you guys have an idea of what you have, just let us know and Millbrook will assist with whatever we can do." Corporal Jamieson's offer was not immediately accepted nor was she given any direction by the Risk Manager at that time. At 10:24 p.m. Corporal Jamieson once again states, "do you want us to start heading that way? We can look for the vehicle or help you guys out there." The response

[14] Foundational Documents RCMP Command Post, Operational Communications Centre and Command Decisions at para 102: COMM0061298

[15] ERT After Action report at p.5: COMM54285

[16] Testimony of SSO Darren Campbell at page 130: COMM61291

[17] Risk Manager Program summary by Inspector Rodier: COMM0062461

received from Cst. Beselt was "ah, we're probably – actually I'm really close. Well just stand by there for right now and we're going to approach here in a second and we'll go from there."[18]

Cumberland RCMP members were also monitoring the Portapique situation and at 10:06 p.m. Constable Basque asks over the Cumberland radio if Colchester needed any help. He is told no, not at this point as they are still getting details. Shortly thereafter, Cumberland members start making their way towards Portapique but in the apparent absence of any apparent specific direction or tasks. At 10:26 p.m. Cst. Carroll, who appears to be monitoring the Colchester radio states, "they're at least going to need our help with securing stuff, at the minimum."[19]

The first direction from the Risk Manager to members is not apparent until 10:44 p.m. when S/Sgt. Rehill states, "we're gonna want somebody to seal off Highway 2 just before you guys – someone there, so we can isolate the scene a bit," to which Cst. Carroll acknowledges and inquires if two vehicles are needed to seal off Highway 2 heading towards Parrsborough. [20]

During this mass casualty, it took over 40 minutes from the time of Ms. Blair's 911 call to see meaningful direction given to responding members and for the request to deploy the Critical Incident package which occurred at 10:46 p.m. By this time, the perpetrator had already murdered 13 people in Portapique and made his escape through the unsecured Portapique perimeter.

- **Reasonableness of the delay**

Superintendent Darren Campbell testified before this commission that the 10:01 p.m. 911 call from Ms. Blair would meet the threshold to call for the Critical Incident Package.[21]

If we analyze Jamie Blair's 10:01 p.m. 911 call discussed above, it is noted that she is calling as a first-hand witness to the possible homicide of her husband. Ms. Blair describes her husband as being shot, that he's lying face down on the deck and that when she went out to check on him, she saw her neighbour advancing up the deck with a firearm. Ms. Blair is petrified and advises the call taker that she's hiding in the back bedroom with her children. She identifies the shooter as her neighbour and that he's a denturist. Ms. Blair provides her address, and confirms her cell phone number. Before the call is ended, Ms. Blair advises that the shooter just broke her lock. Ms. Blair is clearly extremely afraid. The call ends with crying, screaming and sounds that are consistent with gun shots.

Police perform database checks and confirm that there is no police history for this address which would include a history of mischief. Police speculate and subsequently confirm that there is no reason to believe that this call is related to mental health. Police are able to map the address provided by Ms. Blair to a real civic address. Police also obtain subscriber information for the cell phone and associate it to Ms. Blair . Her voice mail also advises that the phone belongs to

[18] Colchester radio *Supra* note 9 at lines 33 and 165-171

[19] Cumberland Radio Transcript at pages 1 and 7: COMM0037124

[20] Colchester Radio, *Supra* note 9 at line 373 and 378. Also see S/Sgt. Rehill's MCC statement at COMM49655

[21] Campbell, *Supra* note 16 at page 131. However, Supt. Campbell does subsequently offer some qualifiers to his initial response but this does not detract from his original answer to the question in my view.

Jamie. Police also have reason to believe that Ms. Blair was a possible witness to a biker gang homicide.[22]

All of the above should provide some circumstantial markers of reliability. You have a presumably reliable complainant that identifies both herself and the subject of complaint. The address provided maps to a civic address and the cell phone voicemail corroborates the name provided to the police by Ms. Blair. Also, the caller comes across as extremely and genuinely afraid. The call ends with crying, screaming and a sound consistent with gun shots. Police are aware that children are also present. There is no reason to deliberate on the veracity or nature of this complaint. If you accept what Ms. Blair is telling you, the situation is dire, and lives are at stake.

And even if further deliberation was warranted, the April 18th, 2020 10:16 p.m. 911 call from the McCully and Blair children corroborates the fact that the original caller and her husband are believed to be deceased, that the perpetrator is driving a cop car as referenced by Ms. Blair, that structures are now on fire (subsequently confirmed by responding members), and that a third possible victim, Ms. McCully, is now missing.

- **Discussion**

The article Imagining grim stories to reduce redundant deliberation in critical incident decision making observes that a persistent criticism aimed at critical incident decision makers is a failure to act in time or at all due, in part, to a pathological overthinking of options due to uncertainty with its outcomes and unfamiliarity with the situation at hand. The decision maker may redundantly deliberate on the nature of the problem in an effort to gain more information instead of committing to the information they have and exercising choices despite the uncertainty of outcome.[23]

Allison (2019) argues as follows:

> With respect to critical incident management, RD (redundant deliberation) 'is the single most damaging decision making failure.' RD occurs at the point where thinking tips into overthinking and where the benefit of calculating the cost of each option shows diminishing returns compared to smoothly picking (or indeed any) of the options over doing nothing. RD leads to failing to act in time (or at all). Delay creates commercial damage to infrastructure, reputational damage to the individual decision-maker and their organization and further catastrophic loss of life.

The search for additional information and subsequent analysis by the decision maker may appear proactive but could be very well be detrimental to the pressing objective of immediacy that is essential during a critical incident.

[22] Colchester radio, *Supra* note 9 at lines 51-94.

[23] Alison, Shortland, Palasinski, Humann (2022) Imagining grim stories to reduce redundant deliberation in critical incident decision making, Public Money and Management, 42:1, 14-21: COMM0058377

- **Recommendations**

1) Address policy pertaining to the early identification of Critical Incidents.

The OCC has identified a series of changes made to operations since this mass casualty.[24] The changes appear very positive but mostly designed to assist after an event has already been identified as a Critical Incident. Under this section, we propose that a broader understanding of what a Critical Incident response means to its community be embedded into policy and training.

As previously noted, the RCMP tactical operations manual defines a Critical Incident as an event or series of events which by their scope and nature require a specialized and coordinated tactical response. Consider other important objectives such as the public's confidence in their police force and embed that into the analysis. As noted by the UK College of policing, "Critical incident management (CIM) is intended to provide a response which satisfies the needs of the victim, their family and the community, but also provides an effective and proportionate outcome to an incident."[25] In 1999, the UK Public Inquiry into the murder of Stephen Lawrence considered systemic issues of racism which resulted in changes to the critical incident model employed by police after finding that how police respond to critical incidents significantly impacts the public's confidence in this institution.[26] As a result the United Kingdom College of Policing adopted the following definition which is still in use today:

> A critical incident is any incident where the effectiveness of the police response is likely to have a significant impact on the confidence of the victim, their family and or the community.[27]

This approach properly places value on the public's confidence in their police force when police are faced with a possible Critical Incident. Understand that 'decision inertia' and efforts to continually gather additional information comes at a cost to the timeliness of the police response which can lead to additional loss of life, and erosion of the victim and public's confidence in the police. As well, it invites an observant approach by the organization as they await direction from command and control.

The RCMP has a duty to respond appropriately to every incident and the prospect of unnecessarily dispatching scarce resources should not be overemphasized. It is a factor of course but if a 911 call describes a critical incident and the information appears to be sufficiently reliable on its own, do not wait for responding members to attend the scene before standing up the tactical teams. Request the critical incident package immediately especially given the

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[24] OCC Enhancements and Initiatives following the April 2020 incident: COMM63180. Of the 47 changes noted, #38 and #39 may apply to this subject which details mandatory CI training for OCC Risk Managers and Staff

[25] UK College of Policing: https://www.college.police.uk/app/critical-incident-management/introduction-and-types-critical-incidents.

[26] The Stephen Lawrence Inquiry, United Kingdom (1999), Recommendations commencing at page 375: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/277111/4262.pdf.

[27] UK College of Policing https://www.college.police.uk/app/critical-incident-management/introduction-and-types-critical-incidents. This definition was also discussed in the article cited at note 23.

inherent delays associated with this service delivery. Also recognize the value in having the first incident commander assuming a proactive posture early when faced with an event given the tone that it sets for your organization. Immediate command and control over a Critical Incident will improve the efficacy of the police response and the victim and public's confidence in its police force. It also provides institutional learning and preparedness for the next event.

At a granular level, consider at a policy level what events require corroboration by attending members and what events don't. If a 911 caller describes a critical incident, are there circumstantial markers of reliability based on the information provided? What details can be corroborated forthwith that speak to credibility or the veracity of the claims made. Recognize that some calls do not require first hand police corroboration that could lead to unnecessary delays. Also, train to assist in making these determinations.

2) Critical Incident Identification Training

We heard during the course of this inquiry that there are already significant training obligations that compete for a police officer's time during the course of a year which includes mandatory training to maintain qualifications. However, very little time appears to be spent on training for discrete events such as Critical Incident Identification[28] likely due to the low probability nature of the event. However, it's important to note that low probability events such as active shooters logically have a very high probability of grievous bodily injury and death. If the Critical Incident response is not fulsome and immediate, the possible loss of life will be unmitigated.

Given the above, it is recommended that Critical Incident Identification training form part of a police officer's curriculum. Critical Incidents necessitate timely and decisive action which may not always be intuitive or consistent with one's personality and temperament.

As discussed above, several studies note that a frequent public criticism of Critical incident responses is that decision makers are not acting in time or at all. The authors of Imagining grim stories to reduce redundant deliberation in critical incident decision- making attribute this, in part, to a pathological overthinking of options by the decision maker in cases where there is no standard operating procedure or sufficient exposure to similar type events.[29]

Laurence Alison (2019) argues that redundant deliberation has catastrophic consequences noted below[30]:

> With respect to critical incident management, RD is the single most damaging decision making failure. RD occurs at the point where thinking tips into overthinking and where the benefit of calculating the cost of each option shows diminishing returns compared to simply picking one . RD leads to failing to act in time or at all. Delay creates commercial damage to infrastructure, reputational damage to the individual decision maker and their organization and further catastrophic loss of life

[28] The training materials included in Relativity speak to Critical Incident training in general. However, I have found no documents that speak directly to training related to Critical Incident Identification.
[29] Critical Incident decision making, *Supra* note 23 page 1.
[30] Critical Incident decision making, Supra note 23 page 2.

To assist in overcoming redundant deliberation, the authors suggest scenario-based training premised on worst case scenarios to assist in predicting, adapting and responding to these events. Frequent training, which does not have to involve lengthy sessions, will increase familiarity and better prepare police officers for these events.

There is a high probability during a Critical Incident that loss of life will be unmitigated until the police provide a fulsome response to the crisis. Early detection is paramount to preserve loss of life and maintain the public's confidence in this institution.

In addition, Critical Incident Identification training can address certain biases that may set in due to lack of exposure to certain events. For example, during the course of this public inquiry we heard from several police officers who advised that they spend an inordinate amount of time responding to nuisance calls[31]. Does this make it more likely that officers will select information from unfolding events that is more consistent with their own experiences? Training can help quell certain biases that may set in due to lack of exposure to uncommon events.

3) Chain of command

Finally, we ask that the Commissioners make recommendations that reduce the levels of approval required for initiation of the critical incident package, and to streamline the chain of contact with National HQ s well as develop a set of factors that guide members in determining if a situation requires a critical incident response. Without clear factors to be considered, the risk remains that incidents will not be declared a critical incident and resources will be withheld with grave consequences, or will not be deployed until much later. If public safety is our priority, we must ensure that procedures and policies align with the fastest and most efficient way to provide resources to the public.

Immediate Action Rapid Deployment (IARD)

- **April 18, 2020**

Cst. Beselt, Cst. Patton and Cst. Merchant, were three of the first four members on scene in Portapique and formed an IARD team to enter Portapique as per their training.[32] All three officers testified as a witness panel on March 28, 2022 and spoke of IARD training they received during the course of their employment with the RCMP. Cst. Patton was a member for 4.5 years and testified that he took the training once during his cadet training at depot. Cst. Beselt advised that he had been an RCMP member for 13 years and took the IARD training once or twice. Cst. Merchant had 15 years of experience and took the training five times. [33]

The officers testified that they themselves made the decision to proceed into the community on foot in pursuit of an active shooter due to fear of ambush as was the case in the tragedies of Moncton, New Brunswick and Spirit Wood, Saskatchewan where officers were shot in their

[31] Testimony of Patton, Beselt, Merchant testimony at page 36: COMM0053615. (This is one of several examples)
[32] Patton et al testimony, *Ibid* at page 71
[33] Patton et al testimony, *Supra* note 31 at pages 73 and 74 for IARD training discussion.

vehicles.[34] The officers had encountered Kate and Andrew MacDonald upon arrival and were aware that the perpetrator was mobile traveling in a vehicle, but maintained their decision to proceed into the community on foot. They also testified that they covered over 10 kilometres that evening while carrying approximately 70 pounds of gear and were understandably exhausted as a result.[35] They described Portapique as a "war zone" on the evening of April 18, 2020 with structures collapsing around them while they heard gunshots and explosions. They also testified that there was no ability for them to be tracked by GPS and they couldn't track other members moving throughout the community.[36] They had no night vision, FLIR and it was dark. They also had to make the decision at various points in the evening to continue to search for the perpetrator in accordance with IARD principles or to check on the four children sheltering in place at 135 Orchard beach Drive.

At one point the IARD team encountered who they believed to be the suspect on Orchard Beach Drive. The officers assumed a prone position and shouted "is there anybody else in here with us, identify yourself right now."[37] The person, now known to be Clinton Ellison, did not respond and proceeded into the woods. The IARD team initially pursued the subject, and contemplated shooting him but terminated their pursuit before entering the woods noting that it would have been too dangerous to do so as they would have been susceptible to an ambush .

The IARD team also had to perform multiple distinct roles through the course of the night – alternating between a contact team with its priority to stop the active threat and a rescue team to monitor and check on the children.

- **Policy**

RCMP Operational Manual Chapter 16.10 provides relevant policy regarding Immediate Action Rapid Deployment.[38] IARD is defined as the "the swift and immediate deployment of law enforcement resources to an on-going, life-threatening situation, where delayed deployment could otherwise result in grievous bodily harm and/or death to innocent persons. It applies to situations where on duty members must stop an active threat causing grievous bodily harm or death. The policy is not a comprehensive guide for members to follow, but provides high level guidance to members such as section 3.1.5. which states that if you are the first member on scene you immediately deploy available resources to stop the active threat in accordance with section 1.9 (priority is to stop the active threat) and IARD training.

Section 1.4 states that to maximize public safety, the member should consider operational support from other members based on a continuous risk assessment with officer safety in mind. As well, consider additional contact teams and/or rescue teams as determined by the continuous risk assessment (Section 3.2.4.1)

[34] Patton et al testimony, *Supra* note 31 at page 68
[35] Patton et al testimony, Supra note 31 at page 131
[36] Patton et al testimony, Supra note 31 at page 94
[37] Patton et al testimony, Supra note 31 at page 105
[38] Immediate Action Rapid Deployment – c.16.10: COMM0039858

- **Discussion**

As noted above, the priority during an IARD is to stop the active threat and to consider backup and additional contact/rescue teams as determined by the continuous risk assessment. Unfortunately, however, during the course of this mass casualty, an off-duty supervisor working from home that had consumed 4-5 drinks of alcohol made the initial decision to deny the entry of additional teams. At 11:21:18 p.m. in response to a request from another member, Sgt. O'Brien states "hold off on the second team, I only want one team in there if we can avoid having anybody else in the crossfire."[39] There is no indication that Sgt. O'Brien turned his mind to the geography of Portapique and considered that teams could have entered Portapique and remained on separate roads which included Portapique Beach Road, Orchard Beach Drive and Cobequid Court to name a few. Also, at this time, the location of the perpetrator was unknown and the members in Portapique continued to hear bangs that they could not decipher. The Blair and McCully children were alone for most of the night awaiting help. It is clear that this appeared to be an ongoing, active threat requiring both contact and rescue IARD teams.

The RCMP Operational Manual pertaining to IARD requires that the member should consider backup from other trained resources and additional contact and rescue teams based on a continuous risk assessment. All available resources should be dispatched to stop the active threat. As Superintendent Campbell noted during his interview, "you're asking me about best practice when you have an active shooter, it's all hands-on deck, so every gun every member should have been in the hunt to stop him."[40]

Prior to Sgt. O'Brien's denial, Cst. Grund inquired about sending in a second IARD team and advised that there were three members who could have formed an IARD team to enter into the community. Constable Dorrington also testified that he would have entered Portapique as part of an IARD team and disagreed with Sgt. O'Brien's decision to deny a second team entry.[41] Sgt. O'Brien testified that his decision to deny Cst. Grund's request to send in a second team into Portapique was not a command decision but rather an accepted statement of IARD training; that you don't send in a second team in these circumstances. Sgt. O'Brien also testified that roughly 30 minutes after issuing the aforesaid command he directed a second team into Portapique to rescue the children at 135 Orchard beach Drive.[42] When asked why his position on sending a second team into Portapique had changed, he referenced, without elaborating, that a risk assessment must have been done, and that this team was going in as a 'contact team." Sgt. O'Brien's initial denial to send in help appears contrary to the principles of IARD which is to stop the active threat and to consider backup and additional teams based on a continual risk assessment. To date we have seen no evidence of this risk assessment being performed. In

[39] Colchester radio *Supra* note 9 line 833. Sgt. O'Brien reversed his earlier decision at 11:50 p.m. and allowed two members to enter to rescue the Blair and McCully children.
[40] Interview of Darren Campbell: COMM0059847 at page 53.
[41] Testimony of Dorrington: COMM0059123 at page 88.
[42] Testimony of Sgt. O'Brien: COMM0058858 at pages 19-30

addition to the aforesaid policy, the training materials uploaded to Relativity also speak to exercises that involves multiple contact and rescue teams entering a hot zone.[43]

The above is highlighted to make the point that IARD policy and training should be updated in light of this mass casualty as its principles and application do not appear to be interpreted similarly by all members. Also, as discussed below, IARD training should consider best practices and lessons learned from this mass casualty to include: night time training in heavily wooded rural areas, when it's appropriate to proceed into a large rural area on foot or in a police vehicle and further guidelines to assist with IARD resource management. Also consider the frequency of which members should take IARD training. In this case, the responding members averaged IARD training once every 4-5 years which does not appear to be notable if your goal is to provide frequent exposure and build a repository of knowledge.

IARD training was identified as an area for improvement in the Independent Review of the Moncton Shooting as noted under recommendation 6.4 which reads:[44]

> Immediate Action Rapid Deployment (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 Operational Communications Centre 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.

The affidavit of RCMP Inspector Croisetiere, dated August 11, 2022 outlines the changes to IARD training since the McNeil report.[45] Paragraphs 90 to 94 note that IARD training is now mandatory for all members. As of April 2017 cadets receive both indoor and outdoor IARD training as part of the cadet training program. IARD was also updated in 2020 to include IARD room entries and clearing, IARD rescues and a ½ day refresher course was added to the Block training in light of the fact that IARD has been a one- time only course.

- **Recommendations**

The Nova Scotia mass casualty occurred in a rural Nova Scotia setting on a dark evening. We respectfully submit that training for all police agencies across Canada must be updated to include a focus on rural settings in various conditions, including nighttime conditions. Barry MacKnight's Report "The Structuring of Policing in Nova Scotia in April 2020" outlines the geographical areas of police agencies and the location of detachments in Nova Scotia.[46] The Report demonstrates that the area covered by an individual detachment in Nova Scotia is vast in many cases, such as the RCMP Bible Hill detachment, and neighbouring detachments, which are responsible to cover Colchester County consisting of more than 3,600 square feet and a population of more than 50,000 residents.[47] Although the Commission does not have a similar

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[43] IARD training materials: COMM0054070 at page 28

[44] Independent Review of the Moncton Shooting (New Brunswick, 2014): COMM0058284 at page 220.

[45] Affidavit of Inspector Croisetiere, August 11, 2022: COMM0062461.

[46] COMM0040450 commencing at p. 26.

[47] Foundational Document First Responder Actions in Portapique: COMM0050894 at p. 33.

Report for all police agencies across Canada, given the vast size of Canada it is expected that police agencies across Canada would also be responsible for large areas depending on their geographical location. As noted by Barry MacKnight in his Report there are challenges for police officers responding in rural areas where they have to travel a great distance from their detachment to where a call is made, as well as relying on resources from neighbouring jurisdictions to assist.[48] From the material disclosed throughout proceedings, we did not come across any IARD material training for rural areas. On cross-examination, the IARD team confirmed that their training did not consist of any exercises in a wooded area in the dark.[49] Given that tragedies such as this can occur in any community across Canada, in a rural or urban setting, and in daylight or darkness, police training must include all such scenarios. We have heard throughout these proceedings that the RCMP is a national police force and as such members can be transferred across the country. As a result, police officers could find themselves in a rural detachment in the future where the required response, including officer resources and technology, may be different than what was used in their previous posting. We recognize that police training cannot anticipate or respond to all possible scenarios. However, we urge the Commission to make recommendations on the following two areas of training:

1) **Outdoor night time & rural IARD training**

Outdoor night time & rural training does not appear to form part of IARD's current curriculum but should be considered a priority for those engaged in contract policing in rural areas. The public reasonably expects that officers will be trained to deliver competent services to their rural areas and should be expected as part of this service delivery. This training should include night time training, as Canadian provinces typically have more hours or darkness than light during the winter months.

2) **Worst case scenario-based training (grim storytelling) & refresher courses**

Based on the evidence we heard during the course of this inquiry, most police officers do not have significant exposure to extreme events and thus must rely on training to develop an expertise in this area of policing. And in order for this training to be meaningful, it must be frequent enough to develop competency. Frequent training can also improve operability within the organization as noted by Professor Kruke in his expert report prepared for this Commission.[50] It is recommended that IARD training be updated to reflect the lessons from this mass casualty. The Commission must consider best practices and discuss the challenges associated to proceeding into an area on foot versus in a vehicle.

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[48] COMM0040450 at p. 19.

[49] Hearing Transcript (March 28, 2020): COMM0053615 at p. 141.

[50] Police and First Responder Decision Making During Mass Casualty Events (2022): COMM0058374

General scene security

This topic has been addressed on several previous occasions in the context of public inquiries and independent reviews. The 2011 inquiry into the Mayerthorpe shooting of four police officers identified the fact that the RCMP did not have a national policy that outlined how a scene was to be secured and as a result recommended that the RCMP adopt National Policy guidelines for the securing of potential crime scenes.[51]

The RCMP responded and on April 23, 2014 included a General Scene Security policy[52]. However, less than two months later on June 4, 2014, the Moncton shootings took place which resulted in the deaths of three police officers. Retired Assistant Commissioner Alphonse McNeil subsequently conducted an independent review which was released by the RCMP on January 15, 2015.[53]

In regards to general scene security, Ms. McNeil notes "It did not appear that the members responding to the Moncton incident had followed the National Policy guidelines for the securing of potential crime scenes, which had been amended following the Mayerthorpe tragedy."[54]

In addition, the Chairperson-Initiated Complaint and Public Interest Investigation into the RCMP Investigation of the Death of Colten Boushie (Civilian Review and Complaints Commission for the RCMP, 2021) found that there were significant delays in the RCMP's attendance at the crime scene. This review investigated the RCMP's handling of the homicide of Colten Boushie, a young indigenous man who was shot and killed in Saskatchewan in 2016. The homicide was reported to police at 5:27p.m. Police arrived at the crime scene shortly thereafter but did not obtain a search warrant for the defendant's property where the murder had taken place until that evening and did not secure evidence or commence a search of the property until the next morning. As a result, key evidence was lost when rain that was forecasted the night before, washed away bloodstain patterns in and around Mr. Boushie's motor vehicle.[55]

The review made two recommendations relevant to this topic of scene security, namely:

> 3. That the RCMP ensure that adequate resources are available in a timely manner for the investigation of major crimes.
>
> ...
>
> 5. That in future cases, the Major Crime Unit Commander ensure that a member of the unit attend the crime scene in a timely fashion.

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[51] Public Fatality Inquiry into the deaths of Constables Anthony Gordon, Lionide Johnston, Brock Myrol, Peter Schiemann ("Mayerthorpe Inquiry") Alberta 2011: COMM0058284 at page 196.
[52] OM 1.2 Scene Security: COMM 17890
[53] Independent Review Moncton shooting (2015): COMM0058284 at page 200
[54] Moncton review, *Ibid* at page 218.
[55] Chairperson Initiated Complaint and Public Interest Investigation into the RCMP investigation of the death of Colten Boushie (2021) COMM:0058284 at page 118

The independent review of the Manitoba Police Services Act (2009) also considered crime scene security and recommended that non police resources such as Community Safety Officers be permitted to assist in non-criminal matters such as guarding crime scenes.[56]

Several previous inquiries have identified general scene security as a significant issue to be addressed by police. Unfortunately, it is apparent that there is still much to be done in this regard as the issue continues to surface- notably with the fact that it took RCMP over 18 hours to secure potential crime scenes within Portapique which includes the fact that the residence of Peter and Joy Bond was not discovered or secured until 4:46p.m. on April 19th, 2020. Portapique also did not have proper inner containment considering that a journalist was able to drive down Brown Loop Road and onto Blueberry Field Road on April 19th at 2:04 p.m. and take a picture.[57]

Throughout this public inquiry, we heard that RCMP resources were stretched thin on April 18 and 19th due to the vast territory covered by the perpetrator but that minimal efforts were made to delegate tasks to their partnering agencies due to concerns over interoperability. However, Chief Superintendant Leather testified on July 28, 2022 that "[he doesn't] see risk associated to what you just described to me," namely whether there would be interoperability concerns with asking Truro Police to canvas Portapique.[58]

It is apparent that the RCMP did not properly turn their mind to scene security nor did they reach out to other police agencies for assistance in this regard during this mass casualty . Several commanding officers, including Sgt. O'Brien and Sgt. Carroll, offered no reasonable explanation as to why there was no proper canvassing of Portapique or why potential crime scenes were left unsecured for so long.

- **Recommendations**

1) Training

As noted above, lack of general scene security has been addressed in several prior inquiries and reviews. However, the fact the RCMP does have a scene security policy dated April 23, 2014 suggests that the issue has more to do with training and examining why members are not turning their minds to this essential task. It is recommended that the RCMP review their training with a focus on why the lessons learned from previous reviews is not forming part of its institutional learning. Examine why this issue continues to be surface when on its face, it does not involve a novel or complex area of policing

2) Policy

Deputy Commissioner Brennan testified that the RCMP has reacted to lessons learned during this mass casualty as it relates to general scene security. He notes[59]:

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[56] Independent Review of the Manitoba PSA: COMM0058284 at page 108
[57] Photograph of Blueberry Field Road: COMM0053537
[58] Testimony of Chris Leather: COMM0061295 at page 72 of page counter
[59] Testimony of Brian Brennan: COMM0064723 at page 50

> Things that we learned obviously from the examination of the mass shooting in Nova Scotia. Engagement in terms of putting specialized resources on the scene. I don't think it needs to be described, but you know, the scenes that needed to be looked after, ensuring we had resources from our forensic identification section, specialists to go in there under that crime scene security, utilizing members, reaching out to the Province and asking, "Are there other peace officer resources that we could possible draw on to do crime scene security at the known sites so that we can deploy our operational members into the investigation?"
>
> So these are just examples of lessons learned that we instinctively undertook within our organization...

It is recommended that policy be formally updated to reflect the lessons learned during this mass casualty. Policy should also encourage partnering with other agencies especially when resources are an issue. Police must significantly raise the bar on this service delivery given the notable history related to this specific issue.

Next of Kin Notification

Recommendations are discussed within this analysis. As raised during our oral submissions made on September 20, 2022, there are significant concerns with the timeliness and manner in which information was shared by RCMP with family members. We will focus on the experience of Harry and Cory Bond, our clients, who are the surviving sons of Peter and Joy Bond. It is now well-known that Peter and Joy Bond were murdered in their home located at 46 Cobequid Court on the evening of April 18, 2020, but their bodies were not discovered until approximately 19 hours later on April 19, 2020. Our clients' excruciating experience is outlined in the Foundational Document: Information Seeking from Families and Next of Kin Notifications[60] and Summary of Meeting with the Family of Peter and Joy Bond.[61] In brief, Harry and Cory Bond made numerous unsuccessful telephone calls to police to obtain information about their parents whom they could not contact. Disclosure received to date only shows the initial call placed by Cory Bond at 10:41 a.m. on April 19, 2020 to 911[62], a call from Harry Bond on April 19, 2020[63] and a call from Harry Bond on the morning of April 20, 2020, as referenced in an e-mail from Michelle Williams, Detachment Services Assistant at 9:06:28 a.m.[64] Harry and Cory Bond are adamant that they made numerous calls commencing the morning of April 19, 2020 to obtain information about their parents. As noted by Michelle Williams on April 20, 2020, Harry Bond telephoned previously with no response and was planning on leaving his home shortly to find answers.[65] After receiving no information from RCMP, Harry and Cory, along with family and friends, travelled more than 2.5 hours from their homes to Portapique to obtain answers. It was

[60] COMM0058972 starting at p. 47.
[61] COMM0058897.
[62] Overview of calls to and from OCC on April 18-19, 2020: COMM0002902 at p. 78.
[63] Email message of phone message: COMM0021192.
[64] Email message of phone message: COMM0016048.
[65] *Ibid.*

not until they travelled to Portapique, provided photographs of their parents to both Cst. Bent and Sgt. Raaymakers that Harry and Cory were finally advised that their parents were murdered. This is not acceptable. No person should have to travel in an upset state to obtain information about their loved ones in the wake of a tragedy, especially after making numerous inquiries with police.

Harry and Cory Bond provided their contact information and details about their parents, but did not receive a telephone call when their parents were discovered deceased in their home on the evening of April 19, 2020. As noted above, it was not until almost 24 hours later when Harry and Cory Bond arrived in Portapique in the afternoon of April 20, 2020 that they were provided any information about their parents. Police were aware as of 10:41 a.m. when Cory Bond first contacted 911 that he was the son of Peter and Joy Bond and looking for information about his parents[66], approximately six hours prior to the eventual discovery of Peter and Joy Bond, and their neighbours, on Cobequid Court. As previously stated, there are no records of the numerous telephone calls made by Harry and Cory Bond. What the records do show is that Harry Bond also telephoned at some point on April 19, 2020 prior to Renée Labranche at the OCC dispatch centre sending an e-mail with Harry Bond's inquiry at 5:32 p.m. to the Major Case Command Triangle.[67], which is approximately 45 minutes after Cpl. MacDonald broadcast over the Colchester Radio at 4:46 p.m. that he discovered a deceased male inside the door of 46 Cobequid Court[68], and around the same time that an officer broadcast over Colchester Radio that there were two deceased bodies discovered at 46 Cobequid Court at 5:37:51 p.m.[69] Based on these broadcasts, it appears that Joy Bond was not discovered until 5:37:51 p.m., approximately 50 minutes after police discovered her husband murdered in their home. Although police may not have completed a formal identification of the deceased, they had more than sufficient information to know the probable identity of the deceased and their next of kin based on information received from Harry and Cory Bond.

In addition to concerns with the records of calls made by Cory and Harry Bond, there are also concerns about the notes provided by RCMP members regarding their interactions with the Bonds, which suggest a different narrative than that recalled by the Bonds. It is respectfully submitted that some notes lack detail and as a result are subject to competing interpretations, which were not explored during this Commission as some authors, such as Cpl. Rose-Berthiaume, were not called upon to testify. We take issue with the handwritten notes of Cpl. Rose-Berthiaume dated April 19, 2020 which show Harry Bond's name and phone number, which has been redacted, along with the names Peter and Joy Bond and an arrow near Harry Bond's name to a NOK to Crystal Mendiuk regarding 41 Cobequid Court.[70] This note is open to interpretation and could suggest that Cpl. Rose-Berthiaume provided a Next of Kin Notification to Harry Bond on April 19, 2020. As noted in the Foundational Document: Information Seeking from Families and Next of Kin Notifications details regarding when Cst. Bent and Cpl. Rose-

[66] Overview of calls to and from OCC on April 18-19, 2020: COMM0002902 at p. 78.
[67] Email message of phone message: COMM0021192.
[68] Colchester radio, April 19, 2020, 12:00:46-17:59:53: COMM0051977 at p. 52.
[69] *Ibid* at p. 61.
[70] Handwritten notes of Cpl. G. Rose-Berthiaume: COMM0005598 at p. 12.

Berthiaume spoke with Harry Bond and the details of those discussions raises questions of when the family of Joy and Peter Bond were advised about their murders.[71] Harry Bond is adamant that he did speak with Cst. Bent on April 20, 2020 and provided him with a photograph of his parents, but was not advised that his parents were deceased until later that day by Sgt. Raaymakers, who compared a picture provided by Harry Bond with the bodies located in the home, when he spoke with him at a roadblock in Portapique.

We ask you, Commissioners, to make as a finding of fact that Harry and Cory Bond were not notified about the death of their parents until Monday, April 20, 2020 by Sgt. Raaymakers. This is the most logical interpretation, as Harry and Cory Bond would not have travelled more than 2.5 hours to Portapique to demand information about their parents on April 20, 2020 had they been provided with this information by the RCMP earlier. This may seem insignificant to some individuals, but it is extremely important to our clients who were left for more than one full day after their first contact with police without any answers despite multiple telephone calls. As stated by Harry Bond to Commission Counsel, he believes that he would have waited even longer, possibly until Tuesday or Wednesday, had he and his family not driven more than 2.5 hours to the home of his parents.[72] In Harry Bond's own words he "thinks that the worst part of the trauma they went through was then they were left wondering what happened. It was the not knowing that was the worst."[73] It is clear that the Bonds went through a long, agonizing process to determine if their parents were murdered. We recognize that the RCMP were busy responding to multiple crime scenes; however, the Bonds had to go through great lengths to obtain information about their parents when there was a record of Cory Bond's inquiry at 10:41 a.m. on April 19, 2020. Although Peter's body was not discovered until 4:46 p.m. and it appears that Joy's body was not discovered until 5:37 p.m. on April 19, 2020, RCMP knew that their children were inquiring about their wellbeing for many hours and some preliminary information could have been provided. We ask you to not only find the timing and circumstances of the Next of Kin Notification as a fact because it is important to our clients, but also because it is an important underlying fact for recommendations to ensure that others in the future do not have to live through the same experience as our clients.

Unfortunately, our clients were not the only ones who struggled to obtain information about their loved ones as evidenced in the Foundational Document: Information Seeking from Families and Next of Kin Notifications.[74] Police agencies need to do better when it comes to communication following a tragedy. The Commission heard from Cst. Fahie that the RCMP has no written policy on how to conduct Next of Kin Notifications.[75] We also heard from Cst. Bent, the officer assigned to be the Family Liaison Officer, that the RCMP has a policy on Next of Kin Notifications, but not for the role of a Family Liaison Officer.[76] We do not recall disclosure of an RCMP policy or manual regarding Next of Kin Notifications as part of the disclosure received to

[71] COMM0058972 at p. 51, para 194.

[72] Summary of meeting with the family of Peter and Joy Bond: COMM0058897 at p. 4.

[73] *Ibid* at p. 6.

[74] COMM0058972.

Hearing Transcript (June 21, 2022): COMM0059676 at p. 58.

[75] Hearing Transcript (May 5, 2022): COMM0057389 at p. 109.

[76]

date. If there is a current policy, it must be examined to determine if it is specific enough to ensure adequate, timely and compassionate information to families and whether it had been followed during the Nova Scotia Mass Casualty. If there is no such policy, we urge Commissioners to develop a policy for all police agencies, not just the RCMP, to ensure not just that a formal Next of Kin Notification is made in a timely manner, but also that information is provided to families prior to a formal identification of deceased being made. Harry Bond told Commission counsel of the steps proposed by the Medical Examiner's Office on April 22, 2020, four days after his parents were murdered, to identify his parents' bodies which would have included couriering a swab to Harry who would then have to complete and courier the swab back to the Office in Halifax before it could be sent to Ottawa or Toronto for examination.[77] Ultimately, the Medical Examiner's Office agreed to send Harry Bond pictures of the bodies via e-mail so that Harry could identify them himself. This highlights the added concern that information will not be shared with families for days or weeks until an official identification is completed, which delays the suffering of families who are trying to obtain information. Harry Bond did not have to wait until the Medical Examiner's Office completed an official identification, as Sgt. Raaymakers previously confirmed that his parents were deceased on April 20, 2020, when he travelled to Portapique and showed a photograph of his parents to receive information. However, there are concerns that police may be hesitant to share information until a formal identification is completed, which lengthens the time families must wait for information and worry about the unknown. In developing or amending a current policy, concerns of sharing information, such as identity of a victim before a formal identification has been made, must be balanced against the need to compassionately respond to the needs of the public who are grieving and looking for answers. Police must do better to provide timely information to families and we urge you, Commissioners, to develop policy and a uniform practice for all police agencies across Canada to follow in such tragedies.

One such recommendation that we urge you to consider is to appoint one person as a contact who ensures that families are responded to in a timely manner when making an inquiry, no more than three hours after their inquiry. Any such recommendations must be specific so that police cannot simply fulfill this obligation by stating that the investigation is still ongoing, but must require that police provide as much detail as possible at the time known. We assert that there was enough information as of 4:46 p.m. on April 19, 2020 to telephone Harry or Cory Bond and advise that at least one individual was located deceased in their parents' home and that further investigation into their identify would be required. Although this information would not be the same as an official Next of Kin Notification it would have provided some information to the Bonds who were fearing the worst and were unable to access their parents' home to confirm for themselves.

[77] Summary of meeting with the family of Peter and Joy Bond: COMM0058897 at p. 10.

In honouring all victims lost in this senseless tragedy, we urge you to make specific and implementable recommendations related to information sharing during similar tragedies, so that no other families must endure similar experiences in the future.

In addition, we urge the Commission to consider expanding the current definition of a critical incident and the role of the Critical Incident Commander to include next of kin notifications. The National RCMP Operational Manual, ch 1.1. Incident Commanders states that based on his or her risk assessment, the Critical Incident Commander will determine when the critical incident is longer deemed a critical incident[78] and will hand over command and control to the appropriate investigative body.[79] Therefore, the Critical Incident Commander has no responsibilities once he or she deems that his or her services are no longer required. The manual defines a critical incident as "an event or series of events which by their scope and nature require a specialized and coordinated tactical response."[80] We submit that the unfortunate events of the Nova Scotia Mass Casualty demonstrate that a critical incident continues even after the threat to public ends, such as in this instance when the perpetrator was killed at the Irving Big Stop. Although the perpetrator was killed the event continued for hours later, as has been demonstrated by the failure to canvas Cobequid Court and the entire community of Portapique until hours after the perpetrator was killed, and ongoing efforts of families and friends to obtain information about their loved ones. S/Sgt. Dan MacGillvary was the Critical Incident Commander in command of the response when the perpetrator was killed and he continued in this position until 3:25 p.m. on April 19, 2020.[81] Therefore, the critical incident was deemed to have terminated at 3:25 p.m., approximately one hour and twenty minutes prior to the discovery of the casualties on Cobequid Court. It is known that many families and friends continued to make efforts to obtain information about their loved ones throughout this period, and many did not receive information until much later. We agree that at some point it is appropriate to hand over control of an event to investigators and other specialized members of the police agency so that essential tasks may be completed. However, it is not satisfactory to hand over control to the appropriate investigative body without ensuring that victims' families are being contacted. The Nova Scotia Medical Examiner Services includes factors to be considered in determining when a critical incident ends.[82] One such factor is when all Next of Kin Notifications that can be contacted have been contacted. As noted above, the RCMP were well aware that Harry and Cory Bond were the next of kin of Peter and Joy Bond and were searching for information about their parents when their murders were discovered. Like the Bonds, other families provided contact information to RCMP throughout this period. Despite the RCMP's extensive knowledge of the possible identity of the victims and contact information of family members seeking information, families continued to wait for information, as it appears that there was no one person designated to ensure that next of kin notifications were completed. We submit that this is an appropriate task for the Critical Incident Commander, in consultation with someone appointed to handle the flow of information,

[78] COMM0018405 at 1.2.1

[79] *Ibid* at 1.2.2.

[80] *Ibid* at 2.1.

[81] Typed notes of Jennifer Reid, Scribed of S/Sgt. D. MacGillvary: COMM0026772 at p. 4.

[82] NSMES Critical Incident Checklists: COMM0059879 at p. 5.

to ensure that families are notified in an appropriate manner and that next of kin notifications be a priority as part of the critical incident response. This will help eliminate future situations where families are left without information for far too long after their multiple inquiries because of a lack of oversight on this critically important task.

Prior Dealings with the perpetrator

Recommendations are discussed within this analysis. We are also concerned with police agencies' prior knowledge of the perpetrator. We have heard through witness interviews with the Mass Casualty Commission counsel and through testimony during the public proceedings that there were at least three complaints made against the perpetrator to police, all of a violent nature and involved firearms. We urge you to consider prior police involvement with the perpetrator so that recommendations can be made to identity and investigate potentially dangerous individuals to make our communities safer.

The first incident involved a complaint on June 1, 2010 by the perpetrator's uncle Glynn to the Codiac RCMP that the perpetrator intended to travel to Moncton, New Brunswick to kill his parents. This 2010 incident is outlined in detail in the Foundational Document Violence in the Perpetrator's Family of Origin.[83] The report outlining the original complaint from Glynn Wortman was shared with Halifax Regional Police and the Bible Hill RCMP Detachment. Sgt. Poirier of the Halifax Regional Police attended the residence of the perpetrator and Lisa Banfield in Dartmouth. It was noted that there was a possibility that the perpetrator was in possession of long-barrelled weapons. When Sgt. Poirier attended the residence, he was advised by Lisa Banfield that there were no weapons in the house, but she would neither admit nor deny the threat against his parents. Lisa Banfield testified on July 15, 2022 that she told Sgt. Poirier that there were no weapons in the home despite knowing that the perpetrator had a handgun in the nightstand.[84] The Halifax Regional Police took carriage of the file since the phone call originated in their jurisdiction and the Bible Hill Detachment was advised that they did not need to check the perpetrator's cottage in Portapique.[85] At 4:41 a.m. on June 2, 2010 a record was added to the HRP's database advising that the perpetrator may be of interest to the Halifax Firearms Interest Police. Sgt. Poirier checked the Canadian Firearms Registry Online and confirmed that the perpetrator did not have a licence to acquire or possess firearms and did not have any registered firearms. A few days later, Sgt. Poirier spoke to the perpetrator on the telephone and was advised that he had a pellet rifle and two antique muskets that are inoperable. Lisa Banfield testified that Cst. Wiley, a friend of the perpetrator, attended their cottage in Portapique in response to this incident.[86] Sgt. Poirier's notes state that he contacted Cst. Wiley to inquire whether the perpetrator possessed any firearms. Ms. Banfield testified that she was present when Cst. Wiley attended the cottage and recalled the perpetrator advising Cst. Wiley that he had a musket and a gun above the fireplace filled with wax as a decoration. Ms. Banfield also testified that she did

[83] COMM0059739 at p. 29.

[84] Hearing Transcript (July 15, 2022): COMM0061288 at p. 63.

[85] Foundational Document Violence in the Perpetrator's Family of Origin: COMM0059739 at p. 34.

[86] Hearing Transcript (July 15, 2022): COMM0061288 at p. 70 and 71.

not see Cst. Wiley conduct an independent search and that she did not speak to him separately from the perpetrator. The Commission also heard from Cst. Wiley on September 6, 2022 that he did not recall attending the perpetrator's cottage for this purpose or speaking to Sgt. Poirier about it.[87] Sgt. Poirier also spoke to the perpetrator's father who advised that he believed his son had firearms, but he had not seen them in approximately five years.[88] Sgt. Poirier attempted to speak with the perpetrator's uncle and father, but was unsuccessful in his attempts. The file was later closed based on the conclusion that there was "insufficient evidence to proceed."

The second incident is known as the 2011 officer safety bulletin and is outlined in detail in the Foundational Document Perpetrator's Violent Behaviour Towards Others.[89] In brief, Cpl. Densmore of the Truro Police Service authored an officer safety bulletin on May 4, 2011that was distributed to law enforcement agencies across Nova Scotia through CISNS after receiving information that the perpetrator stated he wants to kill a cop. The bulletin also advised that the perpetrator was in possession of at least one handgun that he may be transporting between his properties in Dartmouth and Portapique and that he may have several long rifles located behind the flue at his Portapique cottage. The Commission heard that the 2011 CISNS officer safety bulletin was not available to RCMP during the mass casualty as it was previously purged from the system.[90] It is not clear what action was taken with respect to an investigation into the 2011 bulletin. As outlined in the Foundational Document The Perpetrator's Violent Behaviour Towards Others the bulletin was reviewed by Sgt. Poirier of Halifax Regional Police who previously investigated the 2010 threat against the perpetrator's parents.[91] Sgt. Poirier stated in his interview with the Mass Casualty Commission counsel that he spoke to a supervisor at Bible Hill who advised he would provide an update after speaking with Cst. Wiley who responded to the 2010 complaint. Sgt. Poirier stated he never received an update and no further action is noted in Sgt. Poirier's file.[92]

The Commission also heard from Brenda Forbes, a former neighbour of the perpertrator's in Portapique, that she reported to the RCMP that the perpetrator assaulted his partner, Lisa Banfield and was in possession of illegal weapons.[93] The details of this incident are outlined in the Foundational Document Perpetrator's Violence Towards his Common-Law Spouse[94], which were expanded upon during testimony during the public proceedings. Ms. Forbes testified that she was told of the assault by the perpetrator's uncle, Glynn Wortman and that the Ellison brothers were also present.[95] She also testified that she met with two officers at her workplace to provide more details about the assault.[96] Ms. Forbes testified that she was advised by the police

[87] Hearing Transcript (September 6, 2022): COMM0064441 commencing at p. 78.
[88] Foundational Document: Violence in the Perpetrator's Family of Origin: COMM0059739 at p. 37.
[89] Foundational Document: Perpetrator's Violent Behaviour Towards Others: COMM0059623 at p. 5.
[90] Letter/Information stated to families pertaining to information from CISNS: COMM0004836.
[91] Foundational Document: Perpetrator's Violent Behaviour Towards Others: COMM0059623 at p. 56.
[92] *Ibid* at p. 58.
[93] Hearing Transcript (July 12, 2022): COMM0059854 commencing at p. 29.
[94] COMM0059740 commencing at p. 48.
[95] Hearing Transcript (July 12, 2022): COMM0059854 at p. 36.
[96] *Ibid* at p. 38.

that Ms. Banfield had to report the assault and that she needed proof that he had weapons.[97] The Commission heard from Cst. Troy Maxwell, the officer who responded to Ms. Forbes's complaint that the complaint related to the perpetrator driving around Portapique recklessly and being belligerent to neighbours[98] and that no assault was reported by Ms. Forbes.[99] Cst. Maxwell testified that he visited the perpetrator's residence to advise him that a complaint was made against him and that nobody was home. Cst. Maxwell also testified that they did not catch him committing an offence so there was nothing for the RCMP to do other than advise him of the complaint and advise the complainant about the actions.[100] Cst. Maxwell's notes are very limited but contain the names Glynn Wortman, Richard Ellison and Lisa[101], but he could not recall why and was adamant that the complaint was about the perpetrator's driving.[102] Cst. Maxwell also noted that the complaint was about the perpetrator driving a decommissioned police vehicle[103], but Lisa Banfield testified that the perpetrator did not own any decommissioned police vehicles until 2019.[104] The discrepancy in Ms. Forbes's recollection of the complaint and Cst. Maxwell's is concerning, especially since the officer's note are so limited and contain names of individuals reported to have been present during the assault. This is another incident where the perpetrator was reported to police to be violent and in possession of firearms, but the police took no action to investigate the reports by Ms. Forbes.

The Commission must consider recommending procedures to ensure that a proper investigation is completed when a complaint is made, including contacting the victim of an assault if they are not the complainant, to ensure that these incidents do not get filed in a notebook and ignored. In each of these three incidents, clear and unambiguous information that the perpetrator was violent and in possession of firearms was reported to police. The Attorney General of Canada argues in its Phase 2 Written Submissions dated September 2, 2022, that the RCMP and other police agencies did not have sufficient grounds to obtain a warrant in these occasions and that it is unreasonable to suggest that the risk the perpetrator posed was knowable or that law enforcement could have averted the Mass Casualty.[105] We respectfully disagree with this assertion. It appears that some steps in some instances were taken by police, but in others opportunities to conduct a more thorough investigation were missed. We see this as an issue that may continue unless the Commission makes specific recommendations on investigative procedures to be followed by police when similar complaints are made. We submit that recommendations cannot be too broad as uptake from police agencies will be at their discretion and we have heard that the RCMP's response in these instances was appropriate. We recognize that any such recommendations must be balanced with the Canadian Charter of Rights and Freedoms and in particular the right to be secure against unreasonable search and seizure under section 8. However, policies and

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[97] *Ibid* at p. 39-40.
[98] Hearing Transcript (July 19, 2022): COMM0059927 commencing at p. 24.
[99] *Ibid* at p. 108.
[100] *Ibid* commencing at p. 74.
[101] Member's handwritten notes of Cst. Troy Maxwell: COMM0011709.
[102] Hearing Transcript (July 19, 2022): COMM0059927 at p. 34, p. 74 and p. 75.
[103] *Ibid* at p. 30.
[104] Hearing Transcript (July 15, 2022): COMM0061288 at p. 81.
[105] CORR0000273.

procedures that mandate a more meaningful investigation into these complaints should be considered. This would not mean that citizens are subject to a warrantless search, but the police must conduct a more meaningful investigation when these complaints are made and take necessary steps based on the results of their investigation. C/Supt. Leather testified that there were steps that should have been taken in 2011 as an investigation into the complaint forming the officer safety bulletin and that the bulletin on its own would not have been enough to take enforcement action.[106] It is not enough to make a bulletin, a note or close a file without a meaningful investigation. Police must do more when they receive such information to investigate to determine if there is a threat and whether further investigations which could lead to a search warrant and subsequent charges are warranted. In order to obtain a search warrant, the police must conduct a thorough investigation to determine if there are sufficient grounds. This could include various procedures such as interviews with known acquaintances, surveillance, an interview with a suspect, or a cautioned statement. It is only after sufficient steps are taken that a warrant would be issued or the file closed if there is insufficient evidence. However, it is not adequate to simply close a file because police were not contacted by individuals or they did not see the perpetrator commit the offence, as stated by Cst. Wiley. Even if charges are not laid after a thorough investigation, police would have valuable insight into the potential risk posed if prior investigations are noted in detail and can be more proactive in future incidents with the same perpetrator. This was apparent on April 18, 2020 when the identity of the perpetrator was disclosed by Jamie Blair during her initial call to 911,[107] and confirmed by the Blair and McCully children[108] and Kate and Andrew MacDonald in their 911 calls.[109] At 10:30:48 on April 18, 2020 the perpetrator was identified by OCC and his first and last name was broadcast to responding members over the Colchester Radio.[110] Had the CISNS been available to police upon search of the perpetrator's name it would have provided additional information to responding officers about the risk the perpetrator posed as the extent of the casualties and property damage was still unknown at that time. Recommendations from this Commission must address police obligation to investigate such complaints and carry them through to conclusion with detailed notes. Recommendations must also address retention policies so that they are available to other police agencies so that police can be more proactive in the future and have a better understanding of the risk posed when responding to a complaint.

Another issue to be considered with respect to files and bulletins is not just the need to further investigate, but to ensure adequate policies with respect to retention and distribution are addressed. We have heard throughout these proceedings from members of the RCMP that there is concern with interoperability with municipal agencies because they may have different training and different resources. Superintendent Campbell testified before the Commission that there are at least two record managements systems in Nova Scotia.[111] On cross-examination Spt. Campbell testified that he is a "firm believer in one record management system accessible to all

[106] Hearing Transcript (July 28, 2022): COMM0061295 at p. 139.
[107] MCC Transcript of Recorded 911 Calls of Jamie Blair: COMM0003870 at p. 3.
[108] Transcript of 911 Call with AD, AB, AE and AC: COMM0052008 at p. 13.
[109] MacDonald 911 Call: COMM0003851 at p. 4.
[110] Colchester Radio Transcript: COMM0003806 at p. 7.
[111] Hearing Transcript (July 26, 2022): COMM0061291 at p. 91.

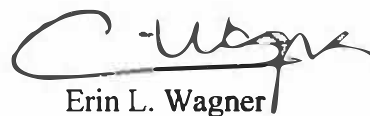
police officers, because being able to access that information can make a significant difference."[112] We urge Commissioners to consider the record management systems among police agencies and improvements that can improve public safety by ensuring that records are kept and all police agencies have the same information at all times. This is important as we saw during the mass casualty that the perpetrator was mobile and covered a large geographical area, crossing police jurisdictions. The public and responding officers should not be at risk in the future because information is only known to one police agency and not others in neighbouring jurisdictions.

ALL OF WHICH IS RESPECTFULLY SUBMITTED this 12th day of October, 2022.

Respectfully,

Joshua E. Bryson

Counsel for the Bond Family



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[112] *Ibid* at p. 91.