File No. 7720-001

July 8, 2022

VIA E-MAIL - participation@masscasualtycommission.ca

The Hon. J. Michael MacDonald, Leanne J. Fitch and Dr. Kim Stanton
Commissioners
Mass Casualty Commission
1791 Barrington Street, Suite 310
Halifax, NS B3J 3K9

Dear Commissioners MacDonald, Fitch, and Stanton:

Re: Phase One Written Submissions

Part 1 – Introduction

April 18 and 19, 2020 will be forever marked in Nova Scotia by the devastating loss of 23 lives. The lives lost included Kristen Beaton and her unborn child who were murdered at approximately 10 a.m. on Sunday, April 19th, 2020. The loss of Mrs. Beaton and her unborn child will forever impact her family including her husband, son, brother, sister, father and "other mother", Beverly Beaton.

The evidence overwhelmingly supports the conclusion that Mrs. Beaton was sitting in her car on Plains Road in Debert while she searched online and through social media for additional information on the perpetrator and his whereabouts. The information Mrs. Beaton was seeking to protect herself with had been in the hands of the Royal Canadian Mounted Police ("RCMP") since approximately 8:00 a.m. that morning. However, it was not released to the Nova Scotia public until 10:17a.m. when it was posted on Twitter.

Suite 300, Park Lane Terraces
5657 Spring Garden Road
Halifax, NS B3J 3R4
902.422.5881 office
902.422.5882 facsimile
www.mdwlaw.ca

The death of Mrs. Beaton and her unborn baby were a result of the RCMP's failure to disclose this information. Their deaths, and those of the 21 other lives lost, were also the tragic result of a cascade of systemic failures, errors, and missteps by the RCMP in discharging its responsibility for executing public safety. It is clear from the evidence that Mrs. Beaton's death was preventable.

The Commission has dealt with difficult truths as it explored its mandate in Phase One of the proceedings, which was [to] inquire into what happened and make findings on:

- The causes, context and circumstances giving rise to the April 2020 mass casualty;
- The responses of police, including the Royal Canadian Mounted Police, municipal police forces, the Canada Border Services Agency, the Criminal Intelligence Service Nova Scotia, the Canadian Firearms Program and the Alert Ready program; and
- The steps taken to inform, support and engage those most affected.

We now have a much deeper understanding of the circumstances which unfolded over the 13 hours from 10:00 p.m. on April 18th to 11:30 a.m. on April 19th, as well as a more robust understanding of how the RCMP's response played an unfortunate but real role in the devastating losses incurred during the Mass Casualty.

<u>Part II – Issues</u>

Submissions on behalf of our client, Beverly Beaton, mother-in-law of Mrs. Beaton, will address the following three broad themes, all of which impacted Mrs. Beaton's ultimate death. Substantive recommendations related to these areas will be addressed in our final submissions at the end of Phase Three.

1. Law Enforcement Resources:
    a. Lack of resources;
    b. Accessing available resources;
    c. Available resources not working; and
    d. Lack of awareness of available resources.

2. Law Enforcement Communications:
    a. Failure to acknowledge and/or deal with victims'/witnesses' reporting of the perpetrator's movements on April 18-19, 2020;
    b. Issues with strategic communications processes in alerting the public, problematic use of social media, and failure to use the Alert Ready System; and
    c. Lack of transparency in the aftermath of the mass casualty.

3. RCMP Accountability:
    a. Systemic lack of accountability/failure to obtain and/or implement recommended resources and processes mandated by the MacNeil/Mayerthorpe Reports; and
    b. Decision making autonomy.

Lastly, we will address our ongoing concerns with the handling of Phase One evidence.

<u>Part III – Discussion</u>

RESOURCES

The evidence highlights significant issues with resources, ranging from resources that were not available, to resources that were available but were not accessed in either a timely manner or at all. As a result, RCMP Members' ability to respond in an optimal way on April 18th and 19th was adversely impacted.

a. Lack of Resources

Colchester County is the second busiest county for policing outside of Halifax Regional Municipality. At a given time there were between 4-6 members on duty and responsible for covering a significant expanse of rural territory. We also understand there is no shift coverage between 2am and 6am.

On April 18th, all available officers (four) were dispatched to Portapique. Three of these members engaged in an Immediate Action Response Deployment ("IARD")

response as they entered the community in search of the active shooter; this left the rest of Colchester County without any coverage.

Based on the Commission's working timeline, Csts. Beselt, Merchant, Patton and Colford (arriving in sequence after 10:25:27 p.m., with the perpetrator allegedly leaving the community at approximately 10:45 p.m.) had the best opportunity to identify and apprehend the perpetrator. However, their ability to contain him was significantly hampered by a lack of resources.

Once Csts. Beselt, Merchant, and Patton entered Portapique on foot, they did so largely blind. They had no night vision goggles and no access to working maps while on foot. They resorted to using their personal cell phones to identify various locations within the community.

RCMP Command confirmed they could not insert a second IARD team because they had no way to track additional Members by GPS, thus making a blue-on-blue situation highly likely. This lack of crucial situational awareness is a significant issue.

Had this tracking ability been available (or utilized), additional IARD teams could have been implemented to eliminate the active shooter threat, and subsequently assist with the evacuation of civilians in Portapique and door-to-door searches throughout the community, including residents of Cobequid Court.

The initial IARD team understood the Portapique area was closed off when they arrived; this was not correct. SSgt. Halliday agreed in his testimony that access to Pictometry "*would have provided a more clear view of what we were dealing with in terms of geography and topography*".

The lack of situational awareness also played a role in Cst. Morrison's shooting. Cst. Morrison relied on his radio communication with Cst. Stevenson when he queried whether she was approaching him. He saw a car coming from the right and understood from Cst. Stevenson's response that it was her. Had he been able to see

her location on his Mobile Workstation ("MWS"), he would not have been taken by complete surprise when the perpetrator approached him.

b. Accessing Available Resources

The evidence confirms multiple instances of Members not accessing available resources. One of the most significant being the lack of access to Pictometry – a mapping tool which, had it been employed, would have clearly shown an alternate route of out of Portapique via the Blueberry Field Road.

One of the first priorities of responding Members was to secure the scene/community. The four initial responding officers, and all who followed thereafter, understood there was only one way in and out of Portapique. This error was perpetuated by the Risk Manager and OCC who relied on outdated mapping technology, which in turn left responding members with incorrect information pertaining to containment of Portapique.

Certain Members, including Cpl. Peterson, did not access their MWS when responding to the mass casualty. Cpl. Peterson lacked the most up to date information about the perpetrator and crucial detail about the replica cruiser he was operating. Every second in an active shooter event is critical. However, Cpl. Peterson exhausted a significant amount of time trying to verify details about the perpetrator's vehicle. His ability to identify the perpetrator would also have been enhanced had he been able to track Members' locations on his MWS.

c. Available Resources Not Working

Optimal Member response efforts were also hampered by available resources which were simply not working. A prime example of this was the Atlantic region RCMP helicopter being out of service without any sufficient contingency plans in place.

Further examples include:

- The RCMP radio system "bonging" out with heavy usage, radio traffic and channel capacity issues, patching issues, and the limitation of use in rural areas; and
- The ERT ATAK system being down, which resulted in a lack of situational awareness and created significant difficulty for the team to function under a "Common Operating Picture".

d. Lack of Awareness of Available Resources

The complete absence of any awareness or consideration by those in command roles to the availability of the province-wide Alert system is the most glaring example of Members' inadequate knowledge of available resources. Despite the explanation by many that it was "*not a tool in the toolbox*", the evidence establishes the RCMP was involved in multiple discussions about its use and potential benefits to policing in the years leading up to the mass casualty.

All the above-referenced resource issues played a role in the perpetrator's escape from Portapique and ability to travel throughout province to continue his killing spree on April 19th.

Rectifying some of these resource issues will take funding. Members cannot be set up for success if they are not provided with the right tools for the job. Other resource issues will take training. SSgt. Briers was an example of someone who was well trained in Pictometry and had used it frequently prior to the mass casualty. One can reasonably assume that had SSgt. Briers been the Risk Manager on the evening of April 18th, he would have accessed the Pictometry system to identify and direct successful containment of Portapique in a timely manner.

COMMUNICATION

a. Failure to acknowledge witnesses' reporting of the perpetrator and relevant situational information on April 18th, 2020

The volume of information received by the RCMP on April 18th, as well as how it was gathered and shared with others, was a significant issue. It is clear from the evidence that systems and Members did not communicate efficiently.

The problem with information sharing started with the first 911 from Jamie Blair and 10:01am and continued throughout the remainder of the mass casualty event. Highly relevant details relayed by Jamie Blair, Andrew and Kate MacDonald, and the Blair and McCully children about the perpetrator within the first 30 minutes, including identifying markings on his vehicle, were not meaningfully captured and/or disclosed to responding Members or subsequently to those in command.

No one was provided with a summary of the initial 911 calls or was able to listen to the 911 calls first-hand. The ERT was stood up at 10:45 p.m. and on the road from Halifax at 11:20 p.m. However, the team did not receive any pertinent information about the perpetrator until they reached Truro, which would have been sometime after midnight.

Information about an alternate access route out of Portapique was provided to Cst. Colford by Kate MacDonald. Cst. Colford conveyed this information over the radio but was not met with any acknowledgment or action in response.

Important information was provided to the RCMP in various ways (911 calls, live interviews, etc.), yet this information was not shared competently, or in some cases, at all. A key area for recommendation will be to consider what can be done to ensure proper communication processes are in place so that large volumes of information can be accurately passed down the line to those individuals who need to make informed decisions and give precise orders.

c. ***Flawed Strategic Communication Processes: failure to communicate with the public in a timely, relevant, and accurate manner, problematic tweeting, and failure to use Alert Ready System***

Despite the availability of three communication methods (media releases, social media and public Alerting), the RCMP only employed social media to alert the public of the active shooter event.

As a starting point, the RCMP's reliance on social media as the sole manner of communicating detail about the perpetrator and the danger to Nova Scotians was a restricted manner of communication. Reliance on Twitter and Facebook automatically excludes a significant portion of Nova Scotians.

Evidence from Cpl. Clarke and Lia Scanlan leads to the easy conclusion that the social media strategy was flawed on many levels. Their evidence confirmed Members were/are paralyzed by red tape, processes, and the formalities of command structure on one hand, while lacking necessary policies and training on the other. There was a constant cycle of chasing, checking, and correcting which led to waste, error and a delay that was directly relevant to Mrs. Beaton's death. The only public communication available to Nova Scotians on social media from 11:00 p.m. on April 18th to 10:03 a.m. on April 19th was that the RCMP was investigating a "firearm complaint" in Portapique. This was wildly misleading and vastly understated the reality of what had happened and what the RCMP knew.

Direction from SSgt. Rehill to disseminate identifying detail about the perpetrator's vehicle was given at approximately 8:00 a.m. Approval of the tweet was given by SSgt Halliday at 9:50 a.m. The tweet was not posted until 10:17 a.m.

Ms. Scanlan confirmed "*communication needs to be as real time as possible*". However, the MOST critical tweet on April 19th involved tasking, delegation, input, drafting, and approval between seven people.

There was also a 27-minute timeframe in which Cpl. Clarke waited for approval on an already approved tweet because of an assumed "*rule of thumb*" requiring "*more approval for bigger events*". This process during a critical incident is unacceptable. Every second is crucial to avoid loss of life. In this case, it is more than reasonable to assume that had this tweet gone out in a timelier fashion, those who were actively using their computers/phones to search for information, like Mrs. Beaton, would have been empowered to protect themselves and survive.

The fact that none of the command structure was aware of the availability of the Alert Ready System is astounding. The evidence is clear that an intrusive alert option for active shooter situations was presented the RCMP by Paul Mason years prior to April 2020. Truro Police were aware of the availability and utility of the Alert Ready System. On its own initiative, EMO mobilized and was ready to engage an alert on the morning April 19th. The only entity unaware of the availability of the Alert Ready System was the RCMP.

The RCMP had a duty to warn the public but failed to do so. It is more than reasonable to assume that the loss of innocent lives would have been less had an Alert gone out on the morning of the 19th.

d. Lack of transparency in the aftermath of the mass casualty

Communication issues continued in the aftermath of the mass casualty. The RCMP's Operational Manual on Media Releases states that public communication should "*report only the facts*". In reality, the public got limited, inaccurate, and incomplete information. The 6:00 p.m. press briefing on April 19th made no mention of the deaths of civilians; this information was only elicited as a result of a media question. Even then, the response provided was knowingly incorrect, as the RCMP downplayed the true death toll (at least 10 vs. 17).

The failure of the RCMP to be transparent and provide "*the facts*" has added to the public's loss of confidence and fundamental mistrust of the organization.

RCMP ACCOUNTABILITY

a. Failure to obtain and/or implement recommended resources/processes MacNeil/Mayerthorpe Reports

A report from Bjorn Ivar Kruke, titled ***Police and First Responder Decision-Making during Mass Casualty Events***, outlines potential barriers to moving forward following mass casualties, stating:

> *Crisis and disasters are often "focusing events" or agenda setting events, attracting attention from media, institutions, and stakeholders. However,* ***learning following a crisis, or a disaster, may be hindered by obstacles such as the political and organizational barriers to effective learning from disasters, blame, the politics of investigations, and the politics of crisis management, all of which may reduce accountability of, and hinder, the important learning processes in the post-crisis phase.*** *There are, in other words, lessons we don't learn. Nevertheless, mass casualty events will happen in the future, and we must therefore take advantage of any learning opportunity we can.*

There is a recurring theme within the evidence of the RCMP, as an institution, of failing to meaningfully take accountability for their actions during the Mass Casualty. There appears to be a reluctance to acknowledge mistakes, to be retrospective and to create change. This is an organizational issue which must be addressed and corrected before there is any hope of learning and changes moving forward.

Errors happen due to flawed processes, not flawed people. The RCMP has significant work to do to address its processes. The lack of training and/or access to technology by RCMP Command, lack of appropriate mapping, issues accessing resources, a lack of clear command structure being followed and uncertainty as to who was in command of what, inefficient tasking and delegation are all examples of processes which were flawed. Processes can be refined but only with the recognition of mistakes and a cultural mindset at the leadership level to learn from the past.

The evidence about the RCMP's willingness to learn from the past by implementing recommendations from relevant reviews raises valid concerns as to what it will do with recommendation flowing from this Commission. The impression left based on the evidence to date is that the RCMP have failed to learn from the past by not proactively and meaningfully implementing recommendations from previous active shooter events.

The failure to implement recommendations from previous shooter events had a direct impact on the April 2020 tragedy. The 2014 MacNeil Review recommended

that each Division *"[d]evelop policy and protocol through Emergency Operational Plan to identify entry/exit points and major transportation routes that would be alerted and monitored in the event of a relevant crisis*".

At 11:00 a.m. on April 19th, the perpetrator travelled from northern Nova Scotia into Southern Nova Scotia at a major entry/exit point that could have been easily monitored by a checkpoint. As early as 7:00 a.m., the RCMP had credible information from Lisa Banfield which indicated the perpetrator's intention to travel to the Halifax area where her sister lived. No steps were taken to action a checkpoint at this critical and major transportation route.

Critical Incident Commanders West and Surette confirmed they read parts of the MacNeil Report on their own time and not as a result of training through the RCMP. They were unaware of whether the MacNeil Report recommendations were implemented in Nova Scotia or whose role it was to implement them. They were not aware of an Emergency Operational Plan being developed to identify entry/exit points or major transportation routes.

We understand a public inquiry is inquisitorial rather than adversarial and its purpose is not to place blame. However, to not be reflective, critical, or highlight unsuccessful actions taken by law enforcement leads to recommendations being made in a vacuum and perpetuates public safety risks. This key lesson learned from the Moncton mass casualty would have had a material impact if implemented in Nova Scotia on April 19th. It is unclear why it was not.

The RCMP Director of Strategic Communications, Lia Scanlan, helped draft the MacNeil Report. However, despite her direct involvement, several communication recommendations have not been actioned in her own unit or the H-Division OCC.

The implementation of the MacNeil Report recommendations, or any well-intention ideas, amount to lip service if Members are not fully informed, educated, or trained on the changes.

Public trust in the RCMP has eroded significantly because of the Mass Casualty events and understandably so. This trust has been further eroded with the realization that recommendations arising from valuable work done in connection with earlier reviews of RCMP' actions following previous active shooter events have not been meaningfully actioned in Nova Scotia.

While we will not deal with recommendations in these submissions, leaving them for the conclusion of Phase Three, it is clear the RCMP organization structure and culture played a significant role in the outcome of April 18th and 19th. Critical to restoring confidence will be to ensure that not only meaningful recommendations will be made but that they will then be meaningfully actioned by the RCMP to help protect Canadians in the future.

b. Decision Making Autonomy

With proper training and processes should come greater autonomy. While there will always be a chain of command, Members operating within that chain and within their roles should be given autonomy for decision making.

Cst. Hubley had this autonomy which was borne out in his ability to make decisions independently. Cpl. Clarke did not feel she had this autonomy despite being given approval by the Acting Operations Officer SSgt. Halliday to disseminate the critical tweet. The bureaucracy of the RCMP naturally serves to hinder independent decision making, as was evident on April 18th and 19th when multiple people were required/involved in the decision making process, which translated into a blurred command structure.

PHASE ONE EVIDENCE CONCERNS

We take this opportunity to raise concerns with the evidence proffered to date and outstanding issues.

On February 28, 2022 we advocated for further evidence from US witnesses Angel Patterson and Sean Conologue. We understand the jurisdictional issues impacting

the issuing of a subpoena but have no understanding of what efforts have been made to obtain further information from these critical witnesses to build as accurate as possible a timeline on April 18th.

In our March 8, 2022 oral and written submissions, we advocated for a witness to address **surveillance evidence**. The intention of this witness was to speak to the process for gathering, analyzing and processing surveillance videos which led to the creation of the timeline created by the Commission relating to the perpetrator's departure from Portapique.

Our submissions were that this witness could speak to what are perceived as discrepancies and inconsistencies with the surveillance evidence which included:

- **Wilson's Gas Bar** – which is relied on for the foundational timestamp tracking the perpetrator's travel of 10:51p.m. in Great Village. The actual surveillance shows no timestamp, yet the Video canvass report notes the timestamp is 47 minutes slow. A MCC Supplementary Report provides additional background about why this is off by 47 minutes.
- **Farmhouse Bakery** – Video Canvas Time stamp is noted to be off – slow by 29 minutes
- **Global Construction** – Video Canvas Time stamp is noted to be "accurate"
- **Angelina's Pizza** – Video Canvas Time stamp is noted to be "exact"
- **Dave's Service Centre –** Video Canvas Time stamp is noted to be "accurate"

Despite Angelina's Pizza and Dave's Service Centre having timestamps that are noted to be "exact" and "accurate", page 20 of the Overnight in Debert Foundational Document states the timestamps for those locations as being "***slightly inconsistent***". This raises questions about the reliability of the video canvass reports which said they were "exact" and "accurate".

We understand the RCMP has a technological crime unit (TCU) that extracts and analyzes digital info and queried whether this was completed. Given the critical importance of surveillance evidence to build reliable timelines, the question of what efforts were made to review the surveillance videos and to enhance and improve their resolution, check files for creation dates, etc. is a foundational one.

Also on March 8th, we suggested a witness to address **forensic evidence** and provide context about how evidence is gathered, analyzed, and processed. We advocated that it was important to take the time to help family members understand how evidence is collected at a crime scene, why some evidence is seized (or not) and what happens with evidence that is sent for analysis (and why some is not). Not laying this important or thorough foundation was viewed as a missed opportunity to help all Canadians understand what happened. Without this evidence, this was specifically unfair to the families who lack any understanding or experience with these processes.

In March 28, 2022 correspondence we requested a **cell phone expert** to review Lisa Banfield's cell phone records and clear up confusion surrounding the timeline of use of the phone.

We understand the Commissioners agreed with the cell phone and surveillance expert, but it is not clear what the results of this have been.

We acknowledge the significant work done by the Commission and its staff. The evidence, through its many forms, has been voluminous and the timeline for completion is daunting. We continue to be committed to working with the Commission within the extent of our available funding and resources to ensure factual gaps are closed and questions answered.

Having said that, we continue to have significant concerns with the evidence being properly tested. The lack of cross examination by participants' counsel based on accommodation requests by two RCMP officers, unilaterally imposed accommodations by the Commission with respect to Lisa Banfield which removed cross examination, reliance on statements that do not include proper follow up questions and/or a deeper dive into the evidence, and the failure to hear from integral Phase One witnesses in a timely manner is not fair to families or the public. The value of the evidence has become overshadowed by a focus on a process which has undermined public confidence and trust.

Lastly, given the date of our retainer, we were not able to provide feedback on any of the Rules. We note the Commission relies on the fact that participants were able to provide input on the Rules in several decisions including its June 17, 2022 decision relating to our motion to amend Rule 52. However, this is not accurate as it relates to our representation given we were retained after the draft Rules were finalized.

We are prepared to speak to these submissions and any questions the Commissioners may have arising from them.

ALL OF WHICH IS RESPECTFULLY SUBMITTED

Tara A. Miller, Q.C. **Alix Digout**

c. Client