Release Date: June 15, 2016

IN THE PROVINCIAL COURT OF MANITOBA

IN THE MATTER OF: ***THE FATALITY INQUIRIES ACT***

AND IN THE MATTER OF: **DAVID DURVAL TAVARES, DECEASED**

(DATE OF DEATH: MARCH 21, 2005)

AND IN THE MATTER OF: **SHELDON ANTHONY MCKAY, DECEASED**

(DATE OF DEATH: MAY 3, 2006

Report on Inquest and Recommendations of
Judge Brent Stewart
Issued this 10th day of June, 2016

APPEARANCES:
Kathrine Basarab and Omar Siddiqui - Justice Manitoba - Public Prosecutions
Mark Mason - Department of Justice (Canada)

Release Date: June 15, 2016

M A N I T O B A

The Fatality Inquiries Act

Report by Provincial Judge on Inquest

Respecting the deaths of:

David Durval Tavares and Sheldon Anthony Mckay,

Having held an inquest respecting the said deaths on April 13 and 14, 2016 at the City of Winnipeg in Manitoba, I report as follows:

The name of the deceased are: DAVID DURVAL TAVARES and SHELDON ANTHONY MCKAY. The deceased came to their deaths while being housed at Stony Mountain Federal Institution in the Province of Manitoba.

I hereby make the recommendations as set out in the attached report.

DATED at the City of Winnipeg, in Manitoba, this 10th day of June, 2016.

"Original signed by:"
Judge Brent Stewart
Provincial Court of Manitoba

Copies to:
Dr. A. Thambirajah Balachandra, Chief Medical Examiner
Chief Judge Ken Champagne, Provincial Court of Manitoba
The Honourable Heather Stefanson, Minister Responsible for *The Fatality Inquiries Act*
Ms. Julie Frederickson, Deputy Minister of Justice & Deputy Attorney General
Michael Mahon, Director of Public Prosecutions
Mark Mason, Counsel for the Federal Government
Kathrine Basarab and Omar Siddiqui, Counsel to the Inquest

[1] This is the inquest report into the deaths of Sheldon Anthony McKay and David (Durval) Tavares.

[2] The inquests are mandated by the Chief Medical Examiner as the deaths occurred while each deceased person was incarcerated at Stony Mountain Institution (SMI). I will summarize the evidence that I have heard on each death separately and then do a global review and recommendation thereafter.

[3] David (Durval) Tavares, who was born on the 16th of September 1964, was killed on March 21, 2005 at SMI, Manitoba. Mr. Tavares's body was found by correctional officers at approximately 22:45 hours in a washroom located in the gym area. He had been beaten and succumbed to his injuries soon after the attack. As a result of this attack, and many years later, three members of the Native Syndicate (NS) street gang were convicted of manslaughter in this death.

[4] The circumstances of this killing were thoroughly canvassed in the subsequent trials of the Native Syndicate offenders whose transcripts of the Queen's Bench hearing were filed in exhibit 21.

[5] Apparently, Mr. Tavares, who was also a Native Syndicate gang member, was being internally punished by the SMI Native Syndicate leadership. He received a D-Board, a physical assault lasting a predetermined amount of time, directed by the Native Syndicate leader against a fellow gang member for a disciplinary reason, where the victim must not defend oneself. To this, he did not recover.

[6] Sheldon Anthony McKay who was born on October 3, 1975, died on May 3, 2006 in his cell at SMI. He was found at 13:40 hours by a correctional officer after having missed a visit by family. He was found face down and unresponsive on his bed in his cell. The cause of death was asphyxia due to neck and chest compression. Similarly to the Tavares matter, some long time later, four members of the Indian Posse (I.P.) street gang were convicted in the murder of McKay.

[7] The transcripts of the Queen's Bench trial were filed as exhibit 13 of this inquest. This exhibit clearly flushes out the circumstances of McKay's death.

[8] Mr. McKay was the gang leader of the I.P. at SMI in May of 2006. He had become a risk to some of the I.P. Council due to his paranoid thinking while in charge. As a result of this, several council members of the SMI I.P. attended to Mr. McKay's cell on the evening of May 3, 2006. They beat and strangled him. He was found the next afternoon, dead, lying in a sleeping position on his bed.

[9] As previously stated, both matters have been thoroughly canvassed by criminal trials previously heard. As the inquest judge, I have been asked to do a review to determine the circumstances of each death and to determine what, if anything can be done to prevent similar deaths from occurring in the future. Due to the fact that these deaths were in a prison setting, this inquest is mandatory (s. 19 of the Fatality Inquiries Act).

[10] The Inquest heard from several representatives from Stony Mountain Institution who gave us background information to help us understand the working mechanisms of a federal correctional institution. Most importantly, we heard evidence from five current or former correctional officers and two who had held the position currently or in the past, as a security intelligence officer.

[11] As an aside, I would note that the terminology used by SMI management, as it relates to street gangs, is to refer to them as "a security threat group" who are housed in their own "subpopulation".

[12] Part of the process of assigning ranges depends on the "compatibility" of these populations. Thus, Indian Posse and Hells Angels become one sub-population, while Manitoba Warriors and B Side Gang form another.

[13] Arising from this evidence, it is clear as one would suspect that the street gang mentality controls most if not all of the daily happenings of a prison system in western Canada. This is most obvious in the "subpopulations" of gangs housed outside of the general population of SMI; in my words, the gang ranges. This carries with it the standard abuse and disrespect which is evident in many of the criminal trials the court sees as it relates to accused persons and the police authority involved. This is especially true in the prison system. In this system, the correctional officers dealing with these criminals must be applauded for their control and patience.

[14] Specifically, we heard evidence that SMI houses more gang members than any other federal prison in Canada. As a result, it is little wonder that in specific units within the prison itself, a siege mentality exists. Little or no intelligence can be garnered from the inmates as to goings on within specific gangs or ranges. Clearly being a "snitch" within a prison would be a dangerous occupation.

[15] In 2005, at the time of the Tavares killing, the various affiliated gang prisoners who were "compatible" to each other were housed apart from the general population in the "crossroads" range. By 2006, when McKay died the security threat groups or gangs, were further segregated into separate ranges with Indian Posse being housed in "F" range. In both deaths, the deceased were killed by their own gang members at the direction of their council leaders.

[16] In the Tavares case, it was as a result of a punishment for his actions on the range. In regards to McKay, an in house coup to remove him from power. Clearly no hint of such acts made their way to the prison's security intelligence office. There is no way in my opinion that such information can be garnered ahead of such an incident. Like the street, the acts of gangs and their leadership are unto themselves and no societal rules will prevent similar incidents. Within the prison itself, as suggested by one of our witnesses, the only way to guarantee that this never happens again is to hold each and every prisoner in solitary confinement with no interaction with each other.

[17] Without going into the extensive evidence filed, I will make some brief comments to provide a background to some of these inquest recommendations.

[18] As it relates to the Tavares death, this happened in the gym/games room/recreational area of the prison. Sometime prior to the incident, the procedure of monitoring inmates in that area changed, whereby, permanently stationed guards were replaced with cameras and correctional officers' physical checks were done twice per hour. In 2005, it is clear that the inmates knew exactly where the camera coverage blind spots were. Likewise, these cameras were somewhat manual and did not cover many areas such as the entry to the gym/recreational area, washrooms, the school area and the prisoners' "general office" area. The purpose for this was not explained. Since the Tavares death, new and more flexible cameras

were installed and most areas of the gym have camera coverage. As to the cell area, no cameras were or are used due to privacy concerns.

[19] At the time of the McKay killing, correctional officers were responsible for performing personal checks on inmates four times per day. These checks were visual observations by correctional officers while the prisoners were locked down in their cells. We heard evidence that often this was through the cell door window where their view was obstructed as a result of inmates covering lights or door windows themselves. This cover up was and is in contravention of institutional policy. Having said that, it appears that such (minor) infractions were often disregarded by inspecting correctional officers and their supervisors.

[20] These checks are conducted at 7:10 am, 11:45 am, 16:30 pm and 22:50 pm. Of these, only the 16:30 pm check was a stand to check. That means that the other three checks were merely a visible check to see that a live body was present in his cell. On the 16:30 pm check, each prisoner was compelled to stand in front of the cell window to be viewed ensuring their presence and wellbeing (a living breathing body count). Since this incident, a second stand to viewing has been established for the 22:50 check. It was clear from the evidence filed, that McKay was killed on the evening of May 3, 2006. He was not found until the afternoon of May 4, 2006. As a result of how the killers positioned his body, his demise was not noted for many hours.

[21] In some ways, the recommendations of this inquest are minor adjustments to an entrenched system. Without substantial resources being invested in added manpower and technology (such as more cameras everywhere and listening devices throughout the ranges which would infringe on *Charter* rights of inmates) little of consequence can be recommended to avert the next gang internal killing. Inmates who are committed to a gang lifestyle will operate within the prison according to gang rules, not society's rules. Based on that conclusion I would recommend the following:

1. As it relates to prisoner checks, all should be stand to checks. The institution's administration expressed concerns mostly relating to the early morning checks and having to wake sleeping prisoners. If that is a difficulty, then the checks should be closer to 8:00 am immediately prior

to breakfast. Whatever inconvenience it causes the inmates, it is offset by the assurance that all inmates have made it through the night and are not in need of medical assistance. However, such a change needs to be approved by senior management in Ottawa. Thus, this would not be implemented in short order, if at all.

2. Assuming that the above recommendation is not quickly forthcoming, proper maintenance of cell lighting must be enforced to ensure that lights and windows are not obstructed nor covered over so that visual spot checks into cells can properly provide a clear view for correctional officers doing their mandatory daily checks.

3. In the gym/recreation area, two permanent guards with proper communication devices should be placed in a secure viewing station so that all aspects of the facility can be viewed and policed.

4. Finally and not directly related to the specifics of this case, the *Fatality Inquiries Act* should be amended to provide a discretionary power to the Chief Medical Examiner as opposed to a mandatory obligation to order an inquest into deaths in prisons. An inquest into these two deaths, being over 10 years old after criminal trials which have worked their way through appeal, accomplishes nothing due to the passage of time and the full disclosure of a jury trial. If inquests are not immediate, the recommendations which flow from them are often stale dated and hold little sway in the making of meaningful changes to the operation of the institutions or personnel in question.

   In addition, the resources invested in an inquest are wasted 10 years after events such as these. Currently, s. 34(1) of the *Fatality Inquiries Act* provides that where the inquest judge is satisfied that the circumstances of death have been adequately examined, then a report to that effect is filed with the Minister of Justice and no inquest is held. The difficulty with this process is that the inquest judge would have to have gone through the evidence of the criminal hearing prior to the holding of a standing hearing. Such evidence is not readily available to a Judge at

that stage. It is my recommendation that the Medical Examiner reviews this evidence and if the matter has been sufficiently examined in the criminal proceeding, that they then be able to stay the Inquest permanently without judicial input. Such is the procedure in seven other provinces in Canada. This should be the procedure in Manitoba as well.

DISTRIBUTION LIST

1. Dr. A. Thambirajah Balachandra, Chief Medical Examiner
2. Chief Judge Ken Champagne, Provincial Court of Manitoba
3. The Honourable Heather Stefanson, Minister Responsible for *The Fatality Inquiries Act*
4. Ms. Julie Frederickson, Deputy Minister of Justice & Deputy Attorney General
5. Michael Mahon, Director of Public Prosecutions
6. Mark Mason, Counsel for the Federal Government
7. Kathrine Basarab and Omar Siddiqui, Counsel to the Inquest
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9. Ms. Aimee Fortier, Executive Assistant and Media Relations, Provincial Court

"Original signed by:"
Brent Stewart, P.J.