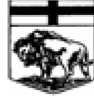
Release Date: December 9, 2016



Manitoba

THE PROVINCIAL COURT OF MANITOBA

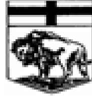
IN THE MATTER OF: *The Fatality Inquiries Act* C.C.S.M. c. F52

AND IN THE MATTER OF: Tyler Joseph St. Paul, Deceased

Report on Inquest of Judge Dale Schille
Issued this 6th day of December, 2016

APPEARANCES:

John Barr, Inquest Counsel
Lisa Cupples and Sean Boyd, Manitoba Justice – Legal Services Branch, Counsel for the Community Safety Division (Corrections Branch)



Manitoba

THE FATALITY INQUIRIES ACT
REPORTED BY PROVINCIAL JUDGE ON INQUEST

RESPECTING THE DEATH OF TYLER JOSEPH ST. PAUL

Having held an Inquest respecting the said death on the 4th and 5th days of May, 2016, at the City of Winnipeg in Manitoba, I report as follows:

The name of the deceased is: Tyler Joseph St. Paul.

The deceased came to his death on the 16th day of May, 2011.

Attached hereto and forming part of my report is a list of exhibits required to be filed by me.

Dated at the City of Winnipeg, in Manitoba, this 6th day of December, 2016.

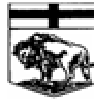
"Original signed by:"

Dale Schille, Judge
Provincial Court of Manitoba

Copies to:

1. Dr. John Younes, A/Chief Medical Examiner (2 copies)
2. Chief Judge Margaret Wiebe, 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. Mr. Michael Mahon, Assistant Deputy Attorney General
6. John Barr, Counsel to the Inquest
7. Lisa Cupples and Sean Boyd, Manitoba Justice – Legal Services Branch, Counsel for the Community Safety Division (Corrections Branch)
8. Exhibit Coordinator, Provincial Court
9. Ms. Aimee Fortier, Executive Assistant and Media Relations, Provincial Court



Manitoba

THE FATALITY INQUIRIES ACT
REPORTED BY PROVINCIAL JUDGE ON INQUEST

RESPECTING THE DEATH OF: TYLER JOSEPH ST. PAUL

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APPENDIX A – EXHIBIT LIST

I. MANDATE OF THIS INQUEST

[1] By letter dated October 17, 2014, the Chief Medical Examiner for the Province of Manitoba (as he then was), Dr. T. Balachandra, MBBS, FRCPC, FCAP, directed that a Provincial Judge conduct an Inquest into the death of Tyler St. Paul for the following reasons:

1. To fulfill the requirement for an Inquest as defined in s. 19(3)(b) of *The Fatality Inquiries Act*;

> **Inquest Mandatory**
>
> 19(3) Where, as a result of an investigation, there are reasonable grounds to believe:
>
> (a) that a person while a resident in a correctional institution, jail or prison or while an involuntary resident in a psychiatric facility as defined in *The Mental Health Act*, or while a resident in a developmental centre as defined in *The Vulnerable Persons Living with a Mental Disability Act*, died as a result of a violent act, undue means or negligence or in an unexpected or unexplained manner or suddenly of unknown cause; or
>
> (b) that a person died as a result of an act or omission of a peace officer in the course of duty;
>
> the chief medical examiner shall direct a provincial judge to hold an inquest with respect to the death.

2. To determine the circumstances relating to Mr. St. Paul's death; and

2. To determine what, if anything, can be done to prevent similar deaths from occurring in the future.

[2] By virtue of s. 33(1), *The Fatality Inquiries Act* requires that the presiding provincial judge:

> (a) make and send a written report of the inquest to the minister setting forth when, where and by what means the deceased person died, the cause of the death, the name of the deceased person, if known, and the material circumstances of the death;
> (b) upon the request of the minister, send to the minister the notes or transcript of the evidence taken at the inquest; and
> (c) send a copy of the report to the medical examiner who examined the body of the deceased person;
>
> and may recommend changes in the programs, policies or practices of the government and the relevant public agencies or institutions or in the laws of the province where the presiding provincial judge is of the opinion that such changes would serve to reduce the likelihood of deaths in circumstances similar to those that resulted in the death that is the subject of the inquest.

[3] The Inquest commenced with notice to the public that a Standing Hearing would be held on October 2, 2015. Standing in this Inquest was granted to the Government of Manitoba, Justice (Corrections). The Inquest heard evidence and submissions on May 25, 26, 27, 31 and June 7, 2016.

II. SUMMARY

[4] The circumstances surrounding the death of Mr. St. Paul were thoroughly canvassed in a review conducted by Corrections. The fact finding aspect of this Inquest was further augmented by the police investigation relating to this death which resulted in criminal charges against numerous individuals.

[5] In May of 2011 Mr. St. Paul was an inmate at Milner Ridge Correctional Centre. Mr. St. Paul was a member of the Most Organized Brothers (hereafter MOB) gang. Mr. St. Paul was housed on the Birch Unit of the institution with other members of the MOB and one other gang.

[6] Mr. St. Paul wished to leave the MOB and join another gang. Gang rules dictate that a person wishing to leave the gang receive a beating administered by other members. Mr. St. Paul had declared an intention to stay on the MOB range and receive the anticipated beating.

[7] The material events culminating in the death of Mr. St. Paul occurred on May 15 and 16, 2011. Staff did not notice anything abnormal prior to Mr. St. Paul requesting assistance the morning of May 16. Institutional video surveillance reviewed subsequent to Mr. St. Paul's death documents a series of abnormal events. On the evening of May 15 surveillance recorded numerous inmates entered Mr. St. Paul's cell. Although there was no camera located inside the cell, it is known that Mr. St. Paul received a beating from other members of his gang. After the beating Mr. St. Paul exited his cell without clothing on his upper body. No injuries were visible. The act of exiting the cell without a shirt on was interpreted to constitute an act of defiance towards the gang to demonstrate that he was unscathed despite the beating.

[8] On the morning of May 16, 2011, numerous members of the MOB again enter Mr. St. Paul's cell and he is beaten again. Numerous inmates are seen on surveillance both entering and leaving the cell.

[9] Following the beating Mr. St. Paul activated an emergency intercom button within his cell to communicate to staff that he was in distress. Staff attended the cell and found Mr. St. Paul conscious and complaining he had been "jumped". Shortly thereafter, Mr. St. Paul lapsed into unconsciousness and attempts to revive him were unsuccessful. The autopsy report listed the immediate cause of death as tension pneumothorax (the progressive build-up of air within the membranes surrounding the lungs, due to a punctured lung, which allows air to escape but not return).

[10] Police were summoned to the institution and an investigation commenced which eventually resulted in criminal charges against eight individuals.

[11] It is the finding of this Inquest that Mr. St. Paul died as a result of homicide.

III. REVIEW OF THE EVIDENCE

[12] Particular aspects of inmate management are identified hereafter as significant factors in the death of Mr. St. Paul.

A. Segregation of Gang Inmates

[13] At the time of his death Mr. St. Paul was a member of MOB. Mr. St. Paul was housed in the Birch Unit which was designated as a gang unit where gang members were segregated from general population inmates. As Mr. St. Paul was killed by members of his own gang, the decision to segregate obviously merits scrutiny.

[14] Segregation of gangs may have the unintended consequence of legitimizing the gang and enhancing its reputation, however, integration has attendant problems with recruitment of general population inmates being the most obvious. The ultimate goal of Corrections concerning gangs is to promote appropriate compliant behaviour.

[15] Corrections constantly monitors the situation within the institution to gauge the effectiveness of the existing approach. Segregation, as it existed at the time of this death, is not a consequence of a firm policy to separate gang members from the general inmate population. It is recognized that a firm segregation policy would likely be counterproductive to moderate behaviour of gang members. Existing policy does allow gang members to be dispersed within general population within the institution as necessary. The potential of dispersing a gang within the institution is an effective management tool.

[16] As the preceding description illustrates, current gang policy is personified by flexibility. Gang members by definition subscribe to a criminal value system and are deeply entrenched in a criminal lifestyle. Such individuals represent a significant challenge to effectively supervise and manage. The reality is that gang members constitute a high risk within an institution. There has been no material change in gang policies since this death. Based on the evidence heard at this Inquest, no aspect of gang policies and procedure is identified as in need of revision.

B. Supervision of Inmates

[17] To understand this issue it is necessary to describe the physical layout of the Birch Unit, the location where this death occurred. Birch Unit is two tiered in design. Each tier has eight cells designed to hold two inmates with a normal unit capacity of 64 inmates.

[18] As previously described, there were numerous inmates in and out of Mr. St. Paul's cell preceding his death. Immediately prior to and during the attack, no staff member was present on the common area of the range. The lone staff member inside the range was in the staff office with several other inmates. Inmate attendance to the office appears to have been a distraction technique to facilitate the attack.

[19] The central feature of oversight was, and continues to be, direct supervision by staff present on the range. In May of 2011 there existed a number of firm expectations relating to supervision which had not been entrenched in policy directives to staff. The most significant expectation was that at least one staff member would be present in the common area of the range to supervise.

[20] There are two staff on duty at all times inside the unit. The expectation at the time of this death was that one of the staff would be on the range situated either in a position to observe the entirety of the range or patrolling throughout the range.

[21] Additional supervision is available from two officers contained in a control pod. As the name would suggest, the control pod is a self-contained unit situated at approximately the same height as the upper tier of the Birch Unit. The pod is placed in a location to provide the ease of surveillance of four other units in addition to the Birch Unit. The five units fan out in front of the pod. The oversight provided by the pod is intended strictly as secondary surveillance and significantly more limited compared to what is provided by officers within the unit. The pod is typically staffed by two officers who have visual surveillance capability over approximately 320 inmates on the 5 different units. Additionally, the pod contains monitors displaying images from more than 20 security cameras. Pod staff are also responsible for activating the doors controlling access to each unit as well as access to each individual cell within each unit. These job responsibilities represent a partial description of overall responsibilities. The job description serves to

illustrate that inmate surveillance is merely one of a myriad of responsibilities for pod staff. No changes to staff levels or responsibilities have been instituted as a consequence of this death. No changes appear necessary from the Inquest perspective (preventing a similar death in the future).

[22] Policy has been established subsequent to this death which mandates staff to physically patrol through the unit, including looking inside cells. Some units are equipped with equipment known as a punch wand system. The system is comprised of a baton wand and "punch" stations located at strategic locations throughout the unit. The wand has the capability to record the identity of the person using it to conduct patrols. At each station the officer places the wand in proximity to the station which is typically located on the wall of the unit at strategic locations. The wand records the fact that the specific officer was present at that location and when. The data from the wand can be downloaded and analyzed periodically to ensure that mandated patrols are being conducted. Currently not all units are equipped with punch wand technology, consequently a paper based sign-in system is also utilized on some ranges as an alternative.

C. Inmate Movement

[23] Inmate movement closely relates to the previous issue of supervision. The ability to supervise and the effectiveness of supervision is a function of the number of inmates present. At the time of Mr. St. Paul's death, both upper and lower tiers were allowed out of their cells simultaneously. Institutional policy has again been changed as a consequence of this death. Current policy allows only one tier out of their cells at a time. The new policy enhances supervision by reducing the number of inmates under observation.

[24] Another material change implemented mandates only inmates assigned to a cell are allowed to be in the cell. This policy precludes, at least legitimately, a group of inmates from entering a cell as occurred during the attack on Mr. St. Paul. At the very least, unauthorized inmates observed entering a cell would now be recognized as abnormal and generate an appropriate institutional response.

D. Private Communications

[25] Subsequent to the death of Mr. St. Paul the institution monitored his previously recorded phone calls. In the course of several telephone conversations preceding the attack upon him, Mr. St. Paul had discussed the fact that he was aware he would be receiving a beating. Despite being aware of the threat Mr. St. Paul intended to stay within the unit and receive his beating “like a man”. These conversations were only subject to monitoring after Mr. St. Paul’s death pursuant to governing legislation. The applicable legislation is s. 42(1) and s. 42(1.1) of *The Correctional Services Act*. The relevant sections read as follows:

> Recording and intercepting inmate communications
> 42(1) The facility head of a custodial facility may, without individualized suspicion, cause inmate communications to be recorded or intercepted in accordance with the regulations.
>
> Monitoring and restricting inmate communications
> 42(1.1) The facility head of a custodial facility may cause inmate communications to be monitored or restricted in accordance with the regulations if
>
> > (a) he or she has reasonable grounds to believe that
> > (i) the communications relate to
> > (A) a criminal offence or a plan to commit a criminal offence, or
> > (B) an act that may jeopardize the safety or security of the custodial facility, or
> > (ii) the inmate is using the communications to harass or cause harm to others;
> > (b) a court order restricts or prohibits communication or contact between the inmate and another person and the communications are directed to that person; or
> > (c) a person has advised the facility head that he or she does not want to communicate with the inmate and the communications are directed to that person.

[26] Milner Ridge Correctional Centre invoked the authority conferred pursuant to s. 42(1) to record Mr. St. Paul’s telephone calls. The institution lacked the authority however, to actually listen to the calls pursuant to s. 42(1.1). Grounds did not exist to satisfy the statutory prerequisites prior to Mr. St. Paul’s death. It is

clear from testimony in this Inquest that Mr. St. Paul would have been deemed at risk and moved immediately had the institution been aware of these phone calls prior to the attack. The ability to monitor inmate phone calls on a large scale without articulable grounds faces two impediments. Notwithstanding a diminished expectation of privacy within a correctional facility, the requirement of articulable cause is premised on a cautiously prudent assessment of the impact of constitutional rights. In addition, monitoring all communications would require a significant investment of resources. Milner Ridge Correctional Centre has the capacity to house in excess of 500 inmates. Recognizing that resources are finite, consideration of wholesale monitoring is simply not realistic. Moreover, there is no evidence to suggest that allocating resources in this way would be prudent or efficient.

IV. RECOMMENDATIONS

[27] The recommendations flowing from this Inquest reflect the reality that the death of Mr. St. Paul is the first homicide in Manitoba of an inmate within a provincial institution. This death, while tragic, represents a highly isolated event. The exceptional nature of this death is a credit to the dedicated staff who work at correctional facilities under challenging conditions.

[28] Several witnesses expressed the view that no measures are available to ensure a similar death does not occur in the future. Inmates cannot be kept isolated from each other. Recognizing that inmates, especially gang inmates, may act in concert to perpetrate an attack on another inmate requiring mere seconds to cause serious injury or death, serves to put the problem in proper context. The recommendations of this Inquest are put forward notwithstanding the reality that there is no capacity to effect reforms capable of preventing a determined inmate from perpetrating a major assault on another inmate. The proposed recommendations are intended to enhance best practices in order to decrease the likelihood of another similar death.

[29] These recommendations also reflect the reality that this report is issued approximately five and one half years subsequent to the death under consideration. The delay is explained in part by the fact that individuals were charged with

criminal offences arising out of this death. The societal interest served by an Inquest seeking to prevent similar deaths is subordinate to the accused's right to a fair trial. This Inquest was consequently delayed until the related criminal prosecutions concluded (eight individuals were convicted of manslaughter).

[30] Given the significant delay in this matter, Corrections conducted a review into the death of Mr. St. Paul. The review was timely and thorough. The report generated by the review contained 25 separate recommendations for changes targeted to enhance operational efficiency and safety. The majority of those recommendations have been implemented or are in the process of being implemented. Corrections is commended for its contemporaneous and thorough response. The scope of the Corrections review and associated recommendations was broader than this Inquest. This Inquest is limited to a consideration of the circumstances designed to generate recommendations to prevent similar deaths.

[31] The recommendations generated by the correctional review were wide ranging and have mostly been implemented. As a consequence, the majority of the significant factors which were potential considerations for recommendations in this Inquest have already been addressed. Those specific areas involve the issues of prisoner supervision and movement earlier discussed.

[32] It is recommended that wand units be made available on all units within the medium security section of the Milner Ridge Correctional Centre. Ensuring that staff are on the range and conducting patrols as mandated would assist in preventing similar deaths in the future.

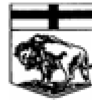
[33] I reiterate a recommendation contained in *The Fatality Inquiries Act* Inquest into the deaths of *David Durval Tavares*, (date of death March 21, 2005) and *Sheldon Anthony McKay*, (date of death May 3, 2006). It is recommended that *The Fatality Inquiries Act* be amended to confer discretion upon the Chief Medical Officer to decline to direct an Inquest in circumstances involving a death occurring within a correctional facility, as in this case. Currently an Inquest is mandatory in such circumstances pursuant to s. 19(3). As previously discussed, this Inquest was conducted several years after the death of Mr. St. Paul and follows both a thorough review conducted by the Corrections Division of Manitoba Justice, a police

investigation and ensuing criminal prosecution. This Inquest represented a critical assessment of practices, policies and procedures which have largely been displaced since the death of Mr. St. Paul. This Inquest expended valuable public resources which might have been conserved had such discretion existed to decline to direct an Inquest into this death.

I respectfully conclude and submit this Report on this 6th day of December, 2016, at the City of Winnipeg, in the Province of Manitoba.

"Original signed by:"

Dale Schille, Judge
Provincial Court of Manitoba



Manitoba

THE FATALITY INQUIRIES ACT
REPORT BY PROVINCIAL JUDGE ON INQUEST

RESPECTING THE DEATH OF: TYLER JOSEPH ST. PAUL

APPENDIX A - EXHIBIT LIST

Exhibit No.	Description
1	Report of Medical Examiner
2	Divisional Review into the Death of Tyler Joseph St. Paul at Milner Ridge Correctional Centre
3	Status of Recommendations Related to Divisional Review into the Death of Tyler St. Paul
4	Queen's Bench Dispositions: Daniel Dumas; Brent Houle; Eric Plante; Eriberto Soldat; Emile Williams and Nathan Allard
5	Photocopies of Information No. 009-70481 and Provincial Court Disposition of Joey Delorande
6	Video Evidence
7	New Officer Evaluation Form