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August 15, 2017

The Honourable Margaret Wiebe
Chief Judge
Provincial Court of Manitoba
5th Floor – 408 York Avenue
Winnipeg, MB R3C 0P9

Inquest into the death of Tyler Joseph St. Paul
Department: Manitoba Justice
Our file 2017-0026

Dear Chief Judge Wiebe:

As you are aware, it is the practice of my office to follow up on inquest recommendations when they relate to a provincial department, agency or municipality.

I am writing to advise you of the results of the inquiries made by my office concerning the inquest report recommendations into the death of Mr. Tyler Joseph St. Paul. The inquest report dated December 6, 2016, was issued on December 9, 2016 by the Honourable Judge Schille.

Mr. Tyler Joseph St. Paul, 21, died on May 16, 2011, as a result of a punctured lung from being beaten by fellow gang members while in custody at Milner Ridge Correctional Centre. The Honourable Judge Schille made two recommendations in the inquest report as follows:

Recommendation One:

[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.

On July 12, 2017, we received the following response to our inquiry regarding the inquest recommendation from Manitoba Justice, the department responsible for Milner Ridge Correctional Centre.

RESPONSE FROM MANITOBA JUSTICE –

The Milner Ridge Correctional Centre installed wand technology in all units, which tracks the time and frequency of officer security checks. Officers are required to complete these checks every 30 minutes in addition to direct supervision (unit presence).

Recommendation Two:

[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.

Regarding recommendation two, our office notes that the Fatality Inquiries Amendment Act was introduced on March 8, 2017, which will, once proclaimed, give the Chief Medical Examiner (CME) more discretion to determine whether an inquest is needed. This would appear to address recommendation two.

On July 12, 2017, we received the following response to our inquiry regarding the inquest recommendation from Manitoba Justice, the department responsible for the Fatality Inquiries Act.

RESPONSE FROM MANITOBA JUSTICE –

With respect to Recommendation Two, as you've noted, recent amendments to the Fatality Inquiries Act will, once proclaimed, address this recommendation.

Given the recently introduced amendments to the Fatality Inquiries Act and that Manitoba Justice has provided its full response to the inquest recommendations, we will conclude our monitoring of the implementation of the inquest recommendations.

Please note, an electronic copy of this report will be posted on the Manitoba Ombudsman website: www.ombudsman.mb.ca.

Yours truly,

Charlene Paquin
Manitoba Ombudsman

c: Ms. Julie Frederickson, Deputy Minister of Justice, Deputy Attorney General
Dr. John Younes, A/Chief Medical Examiner